

ANNOTATED OUTLINE OF THE GLOBAL AIDS STRATEGY 2021–2026

Additional documents for this item: UNAIDS/PCB (47)/20.35; UNAIDS/PCB (47)/CRP3; UNAIDS/PCB (47)/CRP4

Action required at this meeting—the Programme Coordinating Board is invited to:

1. *Recalling* the approval of Option 2¹ through PCB intersessional decision-making process as outlined in the paper *Outcome of the review of the current UNAIDS Strategy 2016–2021 and consultations with an option for the UNAIDS Strategy beyond 2021* (UNAIDS/PCB (47)/20.35);
2. *Take note* of the annotated outline of the global AIDS Strategy 2021–2026;
3. *Request* the Executive Director to present the finalized global AIDS Strategy 2021–2026 for adoption at a special session of the PCB no later than March 2021.

Cost implications for the implementation of the decisions: In the event that the PCB elects to hold a Special Session to adopt the next global AIDS Strategy 2021–2026, the following are cost estimates:

In-person, one-day Special Session (on the basis of estimates from the 2019 March Special Session of the PCB): US\$ 110 000

Virtual, three-hour Special Session: US\$ 45 000

¹ Maintain the critical pillars that have delivered results in the current Strategy, its ambition and the principles underpinning it to the end of 2025, but also enhance the current Strategy to prioritize critical areas that are lagging behind and need greater attention.

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Introduction

1. AIDS remains a pandemic that is under control in only a handful of countries
2. Of the estimated 38 million people living with HIV in 2019, 25.4 million people were receiving antiretroviral therapy (ART), with 12.6 million people still waiting for treatment. In the same year, an estimated 690 000 died of AIDS-related causes.
3. New HIV infections have been reduced by 23% since 2010, thanks in large part to a substantial decrease of 38% in eastern and southern Africa. But HIV infections have increased by 72% in eastern Europe and central Asia, by 22% in the Middle East and North Africa and by 21% in Latin America. In 2019, 1.7 million people newly acquired HIV, far short of the 2020 target of fewer than 500 000 new HIV infections.
4. A majority of countries will fail to reach the 2020 targets set in the current UNAIDS Strategy and the 2016 United Nations (UN) General Assembly Political Declaration on Ending AIDS. Due to the missed HIV prevention targets between 2016 and 2020, an additional 3.5 million people acquired HIV infection and will require HIV treatment for life.
5. Failure to act immediately will cost lives, diminish health and lead to further increases in the costs of treatment—all of which will burden future generations, requiring resources for HIV treatment and care programmes well beyond 2030.
6. HIV-related stigma and discrimination continue to negatively affect the health outcomes and quality of life of people living with HIV, other key populations and those vulnerable to HIV. The tragic impact of the AIDS pandemic and the lagging progress are an urgent wake-up call to do things differently so the international community can get back on-track to end AIDS as a public health threat by 2030.
7. The review of the current UNAIDS Strategy found that the policies, approaches and principles in the Strategy are based on data, evidence and sound programmatic approaches which have delivered results. The review also found that implementation of the current UNAIDS Strategy has been uneven. In many countries and contexts, the evidence-based approaches in the Strategy have not been implemented with sufficient speed, scale, quality and resources to achieve the expected impact.
8. Experience shows that dramatic progress to end AIDS is necessary and possible. Recent years have provided extensive additional evidence, knowledge and experience on how best to respond to HIV, how to move from outbreaks to breakthroughs and even to epidemic transition, and how to improve outcomes, health and well-being for people living with, most at risk and affected by HIV. The process of developing the next global AIDS Strategy capitalizes on this evidence, knowledge and experience. It builds on the policies, approaches and principles in the current UNAIDS Strategy. The AIDS pandemic continues to require a multisectoral response that combines biomedical approaches with attention to key social and structural factors.
9. In 2020, the COVID-19 pandemic has tested the resilience of all health-care systems and has placed the gains made in the global HIV response at risk. COVID-19 has also reminded us that AIDS remains an urgent pandemic. We have the science and tools to prevent each new HIV infection, to avoid each AIDS-related death and to eliminate HIV-related stigma and discrimination.
10. We hear the wake-up call. We cannot afford to fail. There is an urgent need to do things differently in order to get back on-track to end AIDS as a public health threat, as part of the Decade of Action to achieve the Sustainable Development Goals (SDGs) by 2030. Urgency is especially needed to:

- a. ramp up HIV prevention—by intensifying leadership, using combination prevention, ensuring community-led programmes are adequately financed, and removing legal and structural barriers;
 - b. reach the people who are most affected by HIV but are still being left behind, especially people living with HIV, key populations, including young key populations, and women and girls in sub-Saharan Africa;
 - c. meaningfully address inequalities, social enablers and the integration of services;
 - d. tailor the HIV responses to the needs of different population groups in different locations and contexts, investing in evidence-based interventions and community-led responses; and
 - e. close the most glaring gaps of the response (such as paediatric HIV, loss-to-follow-up, and HIV prevention for key population and young people).
11. Part I of this paper summarizes the process to develop the next global AIDS Strategy for 2021–2026. Part II of the paper presents the annotated outline of the Strategy for consideration by the Programme Coordinating Board (PCB) at its 47th meeting in December 2020.

Part I: Process to develop the next global AIDS Strategy

12. At the 45th meeting of the PCB in December 2019, the UNAIDS Executive Director presented her vision for the global HIV response and affirmed that the next UNAIDS Strategy would provide a bridge from 2020 to 2025 and towards the achievement of the target of ending AIDS as a public health threat by 2030 as part of the Sustainable Development Goals (SDGs). She committed to the PCB that the process to develop the next Strategy would be evidence-based, data-driven and highly consultative. She also indicated UNAIDS' plan to present the new Strategy for the PCB's adoption in time to inform the anticipated United Nations (UN) General Assembly High-Level Meeting on AIDS in 2021.
13. At that meeting, the PCB requested the Executive Director to:
- undertake a review of the current Strategy and its implementation, and the results obtained;
 - convene a multistakeholder consultation, with participation of Member States, to present the results of the review and to consider the strategic priorities beyond 2021;
 - present, for consideration by the Board at its 46th meeting in June 2020, options, and their respective processes and timelines, to ensure that the UNAIDS Strategy remains ambitious, visionary and evidence-based beyond 2021; and
 - consult the UN Secretary-General to consider options for the timing of the UN General Assembly High-Level Meeting on HIV and AIDS, and to advise the 46th meeting of the Programme Coordinating Board in June 2020.²
14. To respond to the requests of the 45th PCB, UNAIDS initiated an extensive process to obtain inputs, consultations and a review of evidence on the implementation and results of the current UNAIDS Strategy. This process was initiated as countries, communities and global partners were confronting the COVID-19 pandemic and its health, social and economic consequences.
15. On 6 May 2020, the Executive Director received a request from the PCB nongovernment organization (NGO) delegation to extend the timeline for the review of the current Strategy to ensure that communities affected by HIV would be able to meaningfully engage in the consultations. At its meeting on 7 May 2020, the PCB Bureau expressed support for extending the timeline in light of the challenges posed by COVID-19, but also stressed the

² https://www.unaids.org/en/resources/documents/2019/PCB45_Decisions

need for the next Strategy to be adopted ahead of the anticipated UN General Assembly High-Level Meeting on AIDS in 2021.

16. At the 46th PCB meeting in June 2020, UNAIDS proposed to extend the timeline for the Strategy review and development process. The Executive Director outlined three options for ensuring that the next Strategy remains ambitious, visionary and evidence-based beyond 2021.
 - Option 1: Maintain the focus and structure of current Strategy, extending the timeline to the end of 2025.
 - Option 2: Maintain the critical pillars that have delivered results in the current Strategy, its ambition and the principles underpinning it to the end of 2025, but also enhance the current Strategy to prioritize critical areas that are lagging behind and need greater attention.
 - Option 3: Develop a comprehensive new UNAIDS Strategy from scratch.
17. At the 46th meeting of the PCB, members expressed support for extending the Strategy review and development process timeline. The PCB requested the UNAIDS Executive Director to:
 - present the findings from the completed review of the current UNAIDS Strategy (2016–2021) and the implications for strategic priorities beyond 2021, along with the findings of the independent evaluation of the UN System Response to AIDS 2016–2019 for consideration by the multistakeholder consultation no later than September 2020;
 - following that consultation, present the outcome of the multistakeholder consultation with options for the UNAIDS Strategy beyond 2021 at a briefing for PCB members and observers;
 - present, through the PCB Bureau, a paper on the outcome of the review and consultations with an option for the UNAIDS Strategy beyond 2021 for intersessional approval no later than the end of October 2020; and
 - present to the 47th PCB meeting in December 2020 an annotated outline of the UNAIDS Strategy beyond 2021, ensuring that it remains ambitious, visionary and evidence-based.³
18. The PCB also agreed that a decision would be made at its 47th meeting (December 2020) on the need for a Special Session of the PCB to approve the UNAIDS Strategy, informed by a decision from the President of the General Assembly on the timing of the next UNGA High-Level Meeting on AIDS in 2021.
19. Between June 2020 and November 2020, UNAIDS undertook a series of actions in response to the PCB's requests.
20. The Evidence Review of the implementation of the 2016–2021 UNAIDS Strategy (UNAIDS/PCB (47)/CRP4) was completed in July 2020 and was used as a key input in the Strategy development process. The document is available on the PCB webpage.
21. Inclusive consultations in the Strategy review and development process were undertaken, with the participation of over 10 000 stakeholders globally. Participants included PCB members, government entities (including ministries of health, education and finance), national AIDS commissions, civil society advocates and implementers, people living with and affected by HIV, key populations, young people and faith-based organizations. Also participating were representatives from parliaments, science and academia, philanthropists, donors, the private sector, and global health partners such as the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Unitaid, Stop TB, various foundations, UNAIDS Cosponsors and

³ https://www.unaids.org/en/resources/documents/2020/PCB46_Decisions

members of the UNAIDS Advisory Group. Reports of the consultations are available on the UNAIDS website. Strategy workshops were organized on 20 August and 6 November 2020 to analyse the inputs received and to discuss the issues needing to be addressed in the next global AIDS Strategy.

22. On 16 September 2020, UNAIDS held a global multistakeholder consultation to present the findings of the review of the current UNAIDS Strategy and the implications for the strategic priorities beyond 2021, along with the findings of the independent evaluation of the UN System Response to AIDS 2016–2019. During this consultation, UNAIDS provided an update on the 2025 target-setting and resource needs estimates process, which is integral to the development of the next Strategy. The report from the multistakeholder consultation (UNAIDS/PCB (47)CRP5) has been posted on the PCB webpage.
23. A briefing on the outcome of the multistakeholder consultation was held on 15 October 2020, with participation of PCB members and observers. At the briefing, UNAIDS presented the key messages emerging from the consultations and proposed Option 2 as the way forward to ensure that the next Strategy remains ambitious, visionary and evidence-based. Option 2 calls for the new Strategy to “maintain the critical pillars that have delivered results in the current Strategy, its ambition and the principles underpinning it to the end of 2025, but also enhance the current Strategy to prioritize critical areas that are lagging behind and need greater attention”.
24. Following the PCB briefing, the Executive Director presented, through the PCB Bureau, a paper on the outcome of the review and consultations and proposed Option 2 as the basis for the development of the next Strategy for intersessional approval by the PCB. Through the intersessional decision-making process, the PCB took note of the outcome of the Evidence Review and consultations, as outlined in the paper "Outcome of the review of the current UNAIDS Strategy 2016–2021 and consultations with an option for the UNAIDS Strategy beyond 2021" (UNAIDS/PCB (47)/20.35). The PCB agreed with Option 2, as proposed by the UNAIDS Executive Director.
25. The UNAIDS Committee of Cosponsoring Organizations (CCO) met on 4 November 2020 to discuss the next global AIDS Strategy. The Cosponsoring Heads of Agencies expressed support for the plan regarding the next Strategy, as proposed by the Executive Director. They also showed appreciation for the inclusive process of collaboration within the Joint Programme and the consultation with stakeholders and partners.
26. The CCO emphasized the need to stay focused on the unfinished and urgent business of ending AIDS as a public health threat. It stressed that the next Strategy has to accelerate progress and further ambition to ensure the international community reaches that goal. CCO members recognized that the COVID-19 pandemic has amplified the challenges in reaching the AIDS targets, but also noted that there are opportunities to build on the many positive innovations that had emerged during the COVID-19 response (e.g. simplified HIV testing, multimonth dispensing of antiretroviral medicines, and an increased focus on HIV-sensitive social protection for building resilience). CCO members acknowledged the importance of addressing intersecting inequalities, particularly gender inequality, in the context of HIV, and the importance of building synergies with the broader health and development context to drive results for people living with and affected by HIV.
27. The annotated outline of the global AIDS Strategy 2021–2026, included in Part II of this paper, has been developed on the basis of Option 2. It draws on the Evidence Review, the rich inputs received during consultations, as well as on the expertise of UNAIDS staff across the Secretariat and Cosponsors. Beyond maintaining and building on the critical principles, pillars and programmatic approaches in the current UNAIDS Strategy, the outline also prioritizes critical areas that are lagging behind and that need greater attention for inclusion in the next Strategy.

28. It is anticipated that the next global AIDS Strategy, along with new global HIV targets and resource needs estimates for 2025, will inform the next UN General Assembly High-Level Meeting on Ending AIDS in 2021, as well as the Political Declaration which is expected to emerge from that meeting. It is therefore critical that the Strategy be finalized in advance of the High-Level Meeting, which could take place as early as June 2021 (subject to confirmation by the UN General Assembly).
29. At the time of publication of this paper (25 November 2020), preparations for the High-Level Meeting were in their early stages. On 11 November 2020, the President of the 75th session of the UN General Assembly, H.E. Mr. Volkan Bozkir, appointed H.E. Mr. Mitchell Peter Fifield, Permanent Representative of Australia to the UN, and H.E. Mr. Neville Melvin Gertze, Permanent Representative of Namibia to the UN, to cofacilitate the process related to the convening of the High-Level Meeting on HIV and AIDS. The cofacilitators will begin consultations with Member States to negotiate a resolution to be adopted by the UN General Assembly, which will set forth the modalities for the High-Level Meeting, including the date, duration, scope, format, participation and outcome. Additional details will be provided to the PCB during its 47th meeting in December 2020.

Next steps

30. UNAIDS will continue to lead an inclusive, consultative process to finalize the global AIDS Strategy 2021–2026 after the 47th PCB meeting in December 2020. The Executive Director proposes that the Strategy be finalized in the first quarter of 2021 and be presented to the PCB for adoption at a Special Session of the PCB no later than the end of March 2021.

Part II: Annotated outline for the global AIDS Strategy 2021–2026: A people-centred HIV response

31. The Annotated Outline for the "Global AIDS Strategy 2021–2026: A people-centred HIV response" has been prepared for the PCB as requested at the 46th PCB in June 2020. The purpose of the Annotated Outline is to provide an outline of the key components of the next Strategy, which has been consolidated on the basis of the evidence review and inputs from stakeholders that emerged from the consultations between May and November 2020, in line with Option 2. Stakeholders reaffirmed the vision of zero new HIV infections, zero HIV-related discrimination and zero AIDS-related deaths.
32. The Annotated Outline is a preview of the full Strategy, showing the direction of travel, structure and level of detail towards the full Strategy. The PCB is invited to provide comments and suggestions on this Annotated Outline to guide the finalization of the Strategy. As a preview, the Annotated Outline describes the strategic priorities and corresponding result areas at the level of title, targets, context and core actions. Further details about the "how", including regionalization; roles of partners; use of data, science, research and innovation; and more will be provided in the full Strategy.

Background—changing context of the HIV response

33. The "Global AIDS Strategy 2021–2026: A people-centred HIV response" is a global strategy being co-created with the participation of diverse stakeholders involved in the HIV response. It is based on data and evidence, and it draws on the insights of people living with HIV, networks of key populations, PCB members, national AIDS commissions, government representatives from different sectors, programme implementers, civil society advocates and implementers (including women's rights advocates, young people and faith-based organizations), as well as science and academia, philanthropists, donors, the private sector and global health partners. This is a Strategy for all people and countries, with a direct focus on reducing HIV inequalities and inequities both within and between countries.

34. Status of the HIV pandemic

- Of the estimated 38 million people living with HIV in 2019, 25.4 million people were receiving ART, while 12.6 million people were still waiting for HIV treatment. With an estimated 1.7 million people acquiring HIV and 690 000 people dying of AIDS-related causes in 2019, the pandemic remains an urgent challenge for the world.
- The pace of progress in the HIV response has slowed, with 22 countries and 3 regions reporting at least a 5% increase in new infections and a further 30 countries reporting at least a 5% increase in AIDS-related deaths in the past 5 years. Although substantial HIV transmission continues to occur in sub-Saharan Africa, new HIV infections are increasing rapidly in other regions, including by 72% (since 2010) in eastern Europe and central Asia, by 22% in the Middle East and North Africa and by 21% in Latin America.
- Key populations and their sexual partners now account for the majority of new HIV infections (an estimated 62% of new HIV infections in 2019).
- Progress has been made in preventing new HIV infections among adolescent girls and young women, but at a rate that is far too slow. HIV knowledge among adolescent girls and young women has stagnated. Women and girls in sub-Saharan Africa continue to be the most affected population, accounting for 59% of all new HIV infections in the region in 2019. An estimated 4500 adolescent girls and young women (aged 15–24 years) are acquiring HIV every week in that region. Adolescent girls and young women account for 24% of all new HIV infections in sub-Saharan Africa, even though they constitute only 10% of the region's population. Coverage of HIV treatment for children remains considerably lower than for adults.
- Due to the growing impact of COVID-19 on health systems and the related impact of the global recession, there is a heightened risk that the HIV pandemic may worsen.

35. HIV response

- Fourteen countries (with a diverse range of geographic, economic and epidemic conditions) have passed the 90–90–90 threshold of having at least 73% people living with HIV being virally suppressed. This demonstrates that ambitious targets can be met if strong political will, sufficient financial resources, community-led engagement and comprehensive, evidence-based and human rights-based approaches exist.
- In a larger group of countries with equally diverse range of geographic, economic and epidemic conditions, progress in the HIV response has been limited. Most countries will fail to reach the 2020 HIV targets set out in the current UNAIDS Strategy and in the 2016 Political Declaration on Ending AIDS.
- The funding gap for HIV responses is widening. The investment of HIV resources in low and middle-income countries plateaued in 2017, with funding decreasing by 7% between 2017 and 2019. In 2019, US\$ 18.6 billion was available for the HIV response, which was almost 30% short of the US\$ 26 billion that was committed to for 2020. Domestic investments in HIV responses in low- and middle-income countries have increased by 50% since 2010, but have not continued to increase since 2017. Funding for key populations affected by HIV is badly off-track, with only 2% of HIV expenditure allocated to programmes for key populations.
- Gains are most robust in the area of HIV treatment, with continued progress towards the 90–90–90 targets. However, gains are less pronounced in some regions and among men, children, young people and key populations.
- Despite good examples of evidence-based combination prevention and HIV treatment in several countries, progress remains grossly insufficient in a context of limited investment, focus, quality and scale of programmes. The latest progress report of the Global HIV Prevention Coalition shows that despite declines in new HIV infections among adults in several countries, overall progress in HIV prevention remains variable and too slow.

- Progress on structural and social determinants remains inadequate. Most countries still retain some punitive laws; rates of stigma, discrimination and violence, particularly against key populations and women and girls, while declining in some countries, remain high.
- HIV is inadequately integrated in key health and nonhealth programming.
- Deterioration of the human rights climate, rollbacks on gender equality gains and shrinking space for civil society in many countries have made evidence-based and community-led HIV approaches more difficult to implement and sustain.
- Important innovations in new biomedical tools (e.g. dolutegravir fixed-dose combinations, improved paediatric regimens, injectable long-acting antiretrovirals, pre-exposure prophylaxis or PrEP, and point-of-care diagnostics) and service delivery (e.g. differentiated testing and treatment delivery, multimonth prescriptions, self-care including HIV self-testing and community and pharmacy delivery and use of virtual platforms to support delivery of services) offer important opportunities to scale-up service uptake and outcomes. Rapid progress and continued investment are needed in the development of a HIV vaccine and a cure. These scientific advancements and innovations must be matched with parallel scale-up of programmes that create an enabling environment for people living with HIV in all their diversity and for populations most at risk.
- Urgency, innovation and bold multisectoral leadership are needed to place all countries and communities back on-track for ending AIDS by 2030.

36. Uneven implementation of evidence-informed policies and targeted programmes

- Although the tools exist to end AIDS as a public health threat, HIV responses are faltering due to the failure to implement evidence-informed policies and programmes at scale that prioritize people who are still being left behind.
- Many countries continue to use a “one-size-fits-all” approach without targeting gaps and priorities, based on data and evidence, or they fail to tackle inequalities and structural and legal barriers that are directly related to HIV outcomes.
- While countries invested to scale up HIV treatment to reduce the unacceptable mortality rates caused by HIV, the same levels of attention and financing were not directed at implementing, at scale, the comprehensive HIV prevention approaches which are an essential complement to treatment. Ending AIDS requires a targeted, multisectoral approach to both prevention and treatment.

37. Pandemic preparedness, rapid recovery and global recession

- Before 2020, the global HIV response was not on-track to reach the 2020 Fast-Track targets. The response has been set back further by the COVID-19 pandemic, which is affecting all aspects of life and which poses substantial, long-term risks to the HIV response.
- COVID-19 has disrupted HIV service provision, in particular HIV testing and prevention programming, although some of these effects have been mitigated by innovation, agility and community leadership of the HIV response.
- Data reported to UNAIDS was used to project the potential impact of the COVID-19 pandemic on the HIV response. COVID-19-related disruptions could result in 123 000 to 293 000 additional HIV infections and 69 000 to 148 000 additional AIDS-related deaths globally through 2023 (the range depends on the duration of service disruptions) —a potentially tragic impact that must be minimized with rapid recovery interventions.
- We need to build on the innovations driven by the COVID-19 crisis and ensure that the HIV response remains resilient in the face of other future pandemics and health threats. Despite the bleak projections, we can achieve the new 2025 targets and effectively respond to HIV in the context of COVID-19 and other pandemics if sufficient political

will, global solidarity and shared responsibility exists, and if we build on efficiencies and effectiveness to ensure that these innovations become the new normal.

38. Inequalities and Inequities

- Overlapping and intersecting inequalities and inequities based on gender, income, race, age, ethnicity, culture, disability, origin, drug use, sexual orientation, and gender identity, the criminalization of behaviours or involvement in sex work are acute obstacles to reaching the SDGs, including the goal of ending AIDS by 2030.
- There is a growing body of evidence confirming that living in a setting with greater inequalities is associated with increased individual risk of HIV infection. In many settings, a person with low socioeconomic status faces a higher risk of dying from HIV than a person with higher socioeconomic status. Social and economic inequalities also prevent individuals from accessing HIV services such as testing. Those inequalities are also associated with lower HIV knowledge, lower PrEP use among female sex workers, or lower participation in needle and syringe exchange programmes among people who inject drugs.

Introducing the new global AIDS Strategy

39. Key features of the new Strategy

- The new Strategy will not be a strategy only for UNAIDS. It will be a global Strategy, which articulates future directions for the global HIV response, with an emphasis on regional specificities, Member States, communities, partners and the Joint Programme. The Strategy will be linked to all relevant SDGs, recognizing the need for collaborative efforts across sectors to reach the goals of the 2030 Agenda.
- The new Strategy builds on the 2030 goals and programmatic approaches in the current UNAIDS Strategy, while at the same time addressing specific issues and strategic priorities that have been under-prioritized to date. The new Strategy maintains but reorganizes all eight of the Strategic Result Areas in the current UNAIDS Strategy, recognizing that results in these areas remain critical to ending AIDS. The new Strategy also builds on and draws inspiration from the commitments in the 2016 Political Declaration on Ending AIDS.
- The new Strategy is designed to guide data-driven responses that are tailored to each epidemiological context, to address inequalities and inequities, and to provide clear lines of accountability for different stakeholders.
- The new Strategy will articulate the added value of the Joint Programme and specifies how best UNAIDS can contribute to getting the HIV response back on-track and support the achievement of results across each of the Strategic Priorities and Result Areas which will be further elaborated in the next UBRAF.

40. Evidence-based enhancement and adjustments to improve focus and accelerate progress in critical areas that are lagging behind

- Drawing on the best available evidence, the new Strategy focuses on strategic “game-changers” that can overcome barriers, accelerate progress and help get the response back on-track (e.g. differentiated testing strategies and service delivery for adults and children, combination prevention approaches and new technologies, increased resources for community-led responses, and service integration to make services people-centred and optimally accessible).
- The new Strategy also highlights how under-prioritized issues and populations (e.g. human rights, gender equality, social protection, inequities, and key populations) must receive substantially greater attention and resources in order to end AIDS as a public health threat by 2030.

41. New global HIV targets and resource needs estimates for 2025

- Specific, time-bound targets have driven progress in the HIV response, united diverse stakeholders around common goals and enhanced the transparency and accountability of the response. Getting the HIV response back on-track requires a new set of interim targets for 2025, which are linked to a range of SDG commitments, goals and targets, including but not limited to the SDG target to end the AIDS epidemic by 2030.
- UNAIDS led a three-year consultative process to review available evidence and develop new global targets for 2025. A team of epidemiological modelling experts projected the impact of these targets, which, if achieved, will put the world on-track to reach the goal of ending AIDS by 2030.
- The new targets demonstrate that in order to achieve a significant reduction in new HIV infections and AIDS-related deaths, a core combination of evidence-based HIV services, an enabling environment and adequate resources are needed.
- UNAIDS and partners are working to estimate the financial resources that will be needed to ensure achievement of these targets.
- The deadline to reach the new targets set forth in the new Strategy will be the end of 2025.

Introduction to the framework for the next global AIDS Strategy

42. Under threat of a resurgent AIDS pandemic, the new Strategy targets the barriers and inequalities that have prevented more rapid progress in the last five years. Unless urgent shifts are made to the global HIV response, we are at great risk of having the progress made to-date derailed by crises such as COVID-19 and other emergencies.

43. People-centred continuum of prevention, care and support

- The new Strategy places people at the centre of the HIV response. This requires HIV services, policies and systems that are specifically designed to ensure a continuum of care for people and communities living with HIV, at risk and affected by HIV, with the understanding that human rights, gender equality and social protection policies and programmes are not optional. The new Strategy reaffirms the emphasis on multisectoral responses that address the realities and needs of people in their full diversity and that provide opportunities for communities to engage and lead responses.

44. Overcomes dichotomies and strengthens complementarities

- The new Strategy stresses the need to move beyond counterproductive siloes and false dichotomies and instead encourages strengthening the relationship between:
 - HIV prevention and treatment;
 - health services and the need to address social drivers/enablers;
 - traditional health systems and community-led responses; and
 - what is an “HIV issue” (e.g. condoms, ART, sexually transmitted infections) and what is not HIV-specific but nevertheless is central to progress towards ending AIDS (e.g. education, skills and jobs, and social protection).

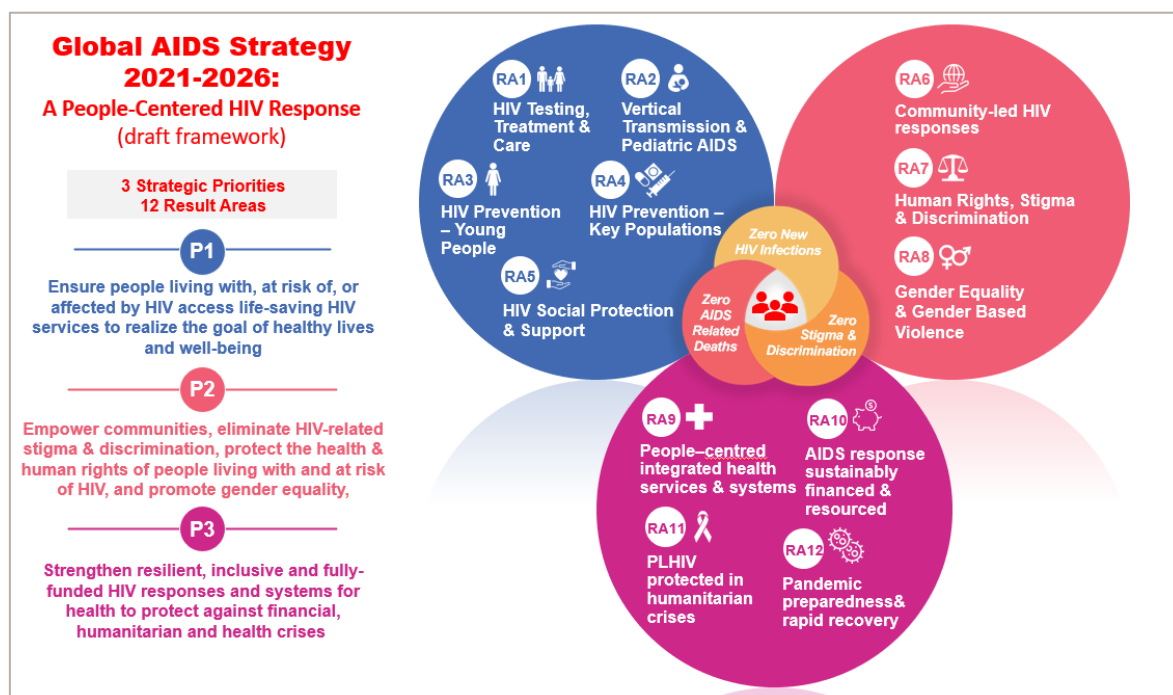
45. Issues needing greater attention and visibility

- The new Strategy adds four Result Areas to the eight Result Areas in the current UNAIDS Strategy. These Result Areas are not new to the HIV response, but rather bring sharper focus and elevate these areas of work for greater impact.
- The four additional Result Areas are as follows.
 - I. Communities. This Result Area recognizes that while affected communities have always had a key role in the HIV response, community-led responses by people living with HIV, key populations, and women and girls remain under-resourced,

under-supported, inadequately integrated in national responses, and subject to considerable challenges.

- II. HIV response in humanitarian and emergency contexts. This Result Area recognizes that the number of countries and people affected by conflict and humanitarian disasters have grown and will continue to do so, especially in light of climate change. This Result Area also takes account of the fact that HIV responses in humanitarian and emergency settings confront unique challenges, requiring more focused, well-coordinated, multisectoral and comprehensive responses.
- III. Social protection and support for people living with, at risk of, or affected by HIV. This Result Area recognizes a key finding from the consultative process for developing the new Strategy: social protection for people living with, affected by HIV and people at risk or vulnerable to HIV is not an optional, but is a fundamental component of an effective, sustainable response to HIV.
- IV. Pandemic preparedness and rapid recovery. This Result Area highlights how to protect the HIV response from the impact of current and future pandemics, taking into consideration the stark changes in the international context caused by COVID-19, which will have a major impact on future global health and development efforts. This Result Area aims to drive efforts to preserve HIV services and responses in the context of health emergencies to adapt HIV responses to support efforts to bring pandemics under control and to mitigate their impact, and to ensure that key lessons of the HIV response are taken on-board to inform the response to COVID-19 and future pandemics.

46. New framework (three Strategic Priorities, twelve Result Areas)



- The new Strategy aims to guide a response which transcends traditional silos and which is more people-centred, inclusive, comprehensive, holistic and synergistic. That aim is reflected in a new framework, which identifies links and commonalities between three overlapping strategic priorities.
 - I. Ensure people living with, at risk of, or affected by HIV access life-saving HIV services to realize the goal of healthy lives and well-being (HIV testing and treatment, prevention and people-centred health services for adolescent girls and

young women, and key populations, elimination of vertical transmission and care and support).

- II. Empower community-led responses, eliminate HIV-related stigma, discrimination and violence, protect the health and human rights of people living with and at risk of HIV, and promote and practice gender equality and end gender-based violence.
- III. Protect inclusive and fully resourced HIV responses and systems for health (including in response to pandemics, responses in conflict-affected and humanitarian settings, health systems, health and financing shocks).

Priorities and Result Areas

Priority I: Ensure people living with, at risk of, or affected by HIV access life-saving HIV services to realize the goal of healthy lives and well-being

47. Perhaps more than any other medical or public health challenge in the last 50 years, HIV illustrates the transformative potential of biomedical research and learning derived from implementation science studies. Although this combination has yielded an impressive service infrastructure that has reduced new HIV infections and AIDS-related deaths, life-saving biomedical tools are still beyond the reach of far too many individuals and communities. Progress in expanding coverage for essential prevention and treatment services has begun to stall, and too many people who access HIV tools and strategies do not remain engaged in services. People and communities who are already marginalized, including people with disabilities and indigenous peoples, risk being left further behind.
48. The new Strategy recommits the HIV response to maximize access to and effective uptake of life-saving HIV services and linkages to social protection that are central to ending AIDS as a public health threat. Achieving this aim will require that HIV services are people-centred, with service systems and approaches adapted to the circumstances and needs of people. Translating this strategic priority from ambition to reality will demand the tailoring of service approaches to the needs of particular groups who are not benefiting equitably.

RESULT AREA 1: Adolescents, youth and adults living with HIV, especially key populations and other vulnerable populations, know their status and are immediately offered and sustained on quality and affordable HIV treatment and care

2025 Targets

Population	Target	Percentage
All subpopulations and age groups	Testing and treatment targets.	95–95–95%
Subpopulations who are living with HIV	Know their HIV status.	95%
Subpopulations who are living with HIV	Know their HIV status are on ART.	95%
Subpopulations who are living with HIV	On ART achieve viral suppression.	95%

49. Current situation, challenges and opportunities

- The expansion of and early access to HIV testing, diagnosis and treatment has improved HIV treatment outcomes and continues to generate significant health benefits, with AIDS-related deaths declining by 39% from 2010 to 2019. However, with 690 000 AIDS-related deaths in 2019, the reduction in AIDS-related mortality falls short of the target of fewer than 500 000 deaths by 2020. Although AIDS-related mortality continues

to decrease, the world is not on-track to reach the goal of fewer than 200 000 AIDS-related deaths by 2030.

- AIDS remains one of the leading causes of death for women of reproductive age.
- Structural and social barriers, including counterproductive laws, stigma and discrimination, continue to prevent access to HIV services and lead to loss-to-follow-up.
- Preventing and addressing interruptions in HIV treatment and ensuring continuity of care dramatically improves outcomes for people living with HIV and supports progress towards national and subnational treatment goals. Low retention on HIV treatment and loss-to-follow-up has undermined progress towards the 90–90–90 targets, resulting in increases in HIV transmission, mortality and morbidity. In sub-Saharan Africa, 22% of patients who were lost to follow-up had died and 23% had discontinued ART.
- Community-led organizations and networks play a key role in identifying and bringing back people living with HIV who have not had any contact, or who have lost contact, with health services.
- Over 7 million people living with HIV in 2019 did not know their HIV status, and over 12 million were not accessing treatment, including a significantly higher proportion of men in high-burden settings and significant gaps among all key populations.
- Late initiation of treatment is one of the major determinants of mortality and treatment failure among people living with HIV.
- Tuberculosis (TB) remains a leading cause of deaths among people living with HIV (one in three AIDS-related deaths are due to TB).
- Key populations continue to be over-represented among those who do not know their status and under-represented in HIV treatment programmes. Unless access to HIV testing and treatment is ensured for key populations and HIV transmission due to untreated HIV is reduced in networks of people at high-risk, epidemic transition will not be possible.
- Expanded access to HIV treatment is reducing new HIV infections; the universal test-and-treat approach showed rapid reductions in HIV incidence of 20–30% when implemented with prevention scale-up.
- A large proportion of people living with HIV reside in middle-, upper-middle and high-income countries, the majority of whom are from key populations. High-income countries face specific challenges as they have to pay higher costs for new health technologies, particularly antiretroviral medicines and health products and tools to screen, detect and treat coinfections (such as for multidrug resistant TB, hepatitis C and human papillomavirus/cervical cancer) and comorbidities highly prevalent among people living with HIV.
- A substantial proportion of individuals who are diagnosed with HIV infection have advanced HIV disease.
- Late initiation of and/or interruption of treatment reduce rates of viral suppression, which contributes to HIV-related illnesses and increases the risk of HIV transmission.
- Interruption of treatment and supplies of medicines can be a serious hindrance to people seeking or receiving treatment and care, and can in turn reduce rates of viral suppression.
- Differentiated service delivery approaches and innovations, developed together with communities, essential to respond to an individuals' specific needs and circumstances and keep them in the continuum of care, are now being broadly taken up, with the COVID-19 crisis providing additional impetus for expedited rollout.

50. Priority actions to achieve targets and results

- a) Address inequities and inequalities, and stigma and discrimination, that affect access to services; expand the scale and improve the quality of testing, treatment, adherence, and care, including an enhanced focus on people who are left behind, loss-to-follow-up, and people in care; maintain continuity of services and linkage/integration with other health and social services. Services must be person-centred, rights-based, community-based, community-led, differentiated, accessible, acceptable, affordable and of high quality.
- b) Urgently address treatment interruptions and ensure continuity of care. Programme attrition can be reduced, and progress towards high levels of viral suppression can be accelerated through active adherence, retention and other support, community and provider monitoring of loss-to-follow-up. Person-centred initiatives to reduce treatment interruptions and re-engage people who have fallen out of care must address key legal, structural, social and individual factors, including poverty, gender inequalities, long distances to health facilities, perception of wellness, community HIV literacy, discrimination and stigmatization, mental health disorders, lack of social support, demand associated with work or child-care or poor health, as well as health system weaknesses. Services and programmes must be improved to respond to the realities of people living with HIV, including people who move within and between countries.
- c) Provide intensive, focused treatment and care for people living with HIV who are in acute need of support (e.g. retention and adherence, psychosocial support, managing advanced HIV disease, HIV drug resistance, food security and nutrition). Linkages to social protection, care and support including cash plus are important.
- d) Address inequity and inequalities (particularly gender inequality), stigma and discrimination in access to testing, treatment and care services by reaching people living with HIV who are left behind, including men, children, adolescents and youth, key populations, people in humanitarian/fragile settings, people with disabilities and other vulnerable groups.
- e) Ensure that key populations are prioritized and that HIV testing and treatment programmes reach them urgently in order to have an impact on the epidemic (reaching 95–95–95 among key populations first will have a major impact on the AIDS epidemic).
- f) Ensure the health and well-being of people living with HIV and key populations through holistic and integrated services, care and support (prevention, screening, detection, treatment and care for coinfections and comorbidities; aging with HIV and other health issues; social protection, legal support, mental health, support for survivors of violence, psychosocial support; drug treatment; employment support, and stigma and discrimination-free environments).
- g) Tailor services for local contexts and local epidemics (urban and rural settings, regional and subnational contexts).
- h) Link testing, treatment and prevention (HIV prevention, testing and treatment continuum for adolescents and adults, including key populations; community-led momentum on HIV treatment as prevention, including effective ART/viral suppression; undetectable=untransmissible (U=U)).
- i) Strengthen and sustain systems for health (strong and resilient health systems; efficient systems that achieve scale; strong community-led systems and scale-up of community-based and community-led services; workplace and education interventions; strategic information and data systems that is adequately granular; removing barriers to access to health technologies).
- j) Invest in community leadership and engagement: mobilization, community-led monitoring and accountability, community-led demand creation, and community-led and -based services.
- k) Invest in scientific research to continue generating important biomedical and programmatic and community implementation advances and innovations.

RESULT AREA 2: Eliminate vertical HIV transmission and end paediatric AIDS**2025 Targets**

Population	Target	Percentage
HIV-exposed newborns and infants	Have access to integrated services to prevent the triple vertical transmission of HIV, syphilis and hepatitis B virus.	95%
HIV-exposed infants	Receive a virologic test and their parents/carers provided with results by age 2 months.	95%
HIV-exposed infants	Receive a virologic test and their parents/carers provided with the final results between 9 and 18 months ⁴ .	95%
All child age groups, all subpopulations and all age groups of women living with HIV	Testing, treatment and viral load suppression coverage targets met.	95–95–95%
Pregnant women	Are tested for HIV, syphilis and hepatitis B surface antigen at least once and as early as possible. (In settings with high HIV burdens, pregnant and breastfeeding women with unknown HIV status during late pregnancy (third trimester) and in the post-partum period).	95%
Syphilis-seropositive pregnant women	Receive syphilis treatment.	95%
Women of reproductive age (including adolescent girls and young women, and women living with HIV)	Have their primary HIV prevention, sexual and reproductive health and family planning needs met.	95%
(NEW) Pregnant and breastfeeding women living with HIV	Have suppressed viral loads.	95%
All child age groups, all subpopulations	New HIV infections	tbd
All child age groups, all subpopulations	AIDS deaths	tbd

51. Current situation, challenges and opportunities

- Adults living with HIV are more likely to access HIV treatment than children (68% and 53% coverage in 2019, respectively), with a much wider gap in certain sub-regions such as western and central Africa (61% for adults versus 33% for children). The world will miss the Fast-Track target of reaching 1.6 million children with HIV treatment (90% of children living with HIV) by 2020. Little progress has been seen in recent years in improving rates of viral load suppression among children living with HIV.
- Among children who receive HIV treatment, outcomes are poor, with only 37% of all children living with HIV achieving viral suppression. Although children accounted for 5% of people living with HIV in 2019, they represented 14% of all AIDS-related deaths, with most deaths among children occurring in the first four years of life. Globally, more than

⁴ This will still miss about half of infections during breastfeeding.

two-thirds (67%) of children living with HIV who are not receiving treatment are aged 5–14 years.

- Current testing approaches miss many children living with HIV. The large number of children who are living with HIV but who are not receiving HIV treatment stems primarily from two key testing gaps: (1) low coverage of early infant diagnostic services; and (2) the lack of testing options for older children who are missed by early infant diagnosis efforts, especially children who acquire HIV during breastfeeding.
- Service delivery barriers and weaknesses impede progress in reaching women and children in different contexts: women’s inadequate access to HIV prevention; sexual and reproductive health and family planning services; stagnating ART coverage among pregnant women, substantial treatment interruptions; late presentation for antenatal care services and insufficient HIV and viral load testing of women during later stages of pregnancy and breastfeeding; gaps in family testing and other strategies to identify children missed by early infant diagnosis; and insufficient use of optimal paediatric formulations, interventions and support to retain children in care.
- Legal and policy barriers, and stigma and discrimination impede progress in addressing children’s and adolescents’ HIV-related needs, such as not prioritizing transition to optimized treatment regimens; requirements for parental consent for adolescents seeking to access HIV testing and sexual and reproductive health services; and failure to ensure women-centred services, which results in continuing stigma and discrimination, gender-based violence, and other rights violation.
- Progress in addressing the HIV-related needs of children is undermined by health system weaknesses, including weak data systems, insufficient use of granular “stacked-bar” analyses to identify and address key gaps, and underlying weaknesses in service platforms and integration of services for sexual, reproductive, maternal, newborn, child and adolescent health.
- Prevention and treatment of paediatric HIV do not receive sufficient priority in national budgets, HIV strategies and funding requests.

52. Priority actions to achieve targets and results

- a) Reinvigorate political leadership, reaffirm global, regional and national commitments, earmark greater and more targeted funding, incentivize research and development, and advocate strongly to accelerate progress towards elimination of vertical transmission of HIV and syphilis, as well as hepatitis B among children in ways that respect and protect human rights.
- b) Develop regional and national roadmaps, with partner-accountability frameworks to accelerate towards elimination of vertical transmission of HIV, syphilis and hepatitis B and to end AIDS in children.
- c) Set interim 2023 ARV treatment target for children and report on progress: “Commit to 95-95-95 testing, treatment and viral load suppression targets by 2025, with special emphasis on providing 95% of children living with HIV (0-14 years of age) with antiretroviral therapy by 2023”.
- d) Urgent action is needed to scale up paediatric ARV treatment as 50% of infants living with HIV will die by the age two if they do not receive ARV treatment.
- e) Deliver equitable access to optimized technologies for preventing, diagnosing, treating HIV in children, including EID, optimized ART regimens for all age and weight groups, viral load testing, and service delivery models that are tailored to changing needs over the lifecycle and that enable adolescents and young people to achieve their full potential free from stigma and discrimination.
- f) Urgently find, test, treat and achieve viral load suppression for the missing mothers and children living with HIV through scale-up of integrated contact tracing with partner/family/household and hot-spot testing (including HIV, TB, viral hepatitis, syphilis

and immunization updates), with particular attention to the needs of less-educated women and women living in rural areas and poor urban settlements, and women in key populations.

- g) Where warranted, ensure pregnant and breastfeeding women are afforded the opportunity to test and re-test for HIV, and deliver combination HIV prevention adapted to their needs, including PrEP and syphilis testing for women who are at substantial risk of HIV infection. Strengthen referral systems with nutrition programmes for early HIV identification.
- h) Establish and invest in robust community-led and community-based services that are centred on the needs of women and children, and support them to access testing and meet their needs for HIV prevention and treatment, including services and support led by women living with HIV, such as mentor mothers. Ensure access for women to sexual and reproductive health services. Address childhood development and immunization needs, from conception to the end of breastfeeding.
- i) Strengthen health information systems to be able to collect, analyse and use age-disaggregated programmatic data to identify gaps and hotspots and targets services where they are needed most, enable longitudinal and cohort studies, and demonstrate impact at subnational, national, regional and global levels.
- j) Strengthen and sustain political and financial support for eliminating vertical HIV transmission and ending paediatric AIDS and effectively address the legal, social and structural factors that increase vulnerability to HIV and that act as barriers to accessing voluntary, consensual integrated HIV, sexual and reproductive health, maternal and newborn child health and immunization services, stigma and discrimination, violence, criminal laws, issues of consent and coercion, gender inequality, human rights violations and inadequate social protection.

RESULT AREA 3: Young people access sustained combination HIV prevention

2025 Targets

Population	Target	Percentage
All young people	Have their primary HIV prevention, sexual and reproductive health and family planning needs met.	95%
Young people at risk of HIV infection	Use appropriate, prioritized, person-centred and effective combination prevention options, by 2025.	95%
Adolescents and young people in (high, moderate, low) HIV risk stratum	Used condoms/lubricants at last sex.	(95, 70, 50%)
Adolescents and young people in (high, moderate, low) HIV risk stratum (HIV negative young people)	Are enrolled on PrEP.	(50, 5, 5%)
Adolescents and young people in (high, moderate, low) HIV risk stratum	Receive screening and treatment for sexually transmitted infections.	(80, 10, 10%)
All young people	Receive comprehensive sexuality education, in line with UN international technical guidance.	90%
Adolescents and young people in (very high, high, moderate) HIV risk stratum	Have access to post-exposure prophylaxis following nonoccupational HIV exposure, as part of a package of risk assessment and support.	(90, 50, 5%)

Adolescents and young people in (very high, high, moderate, low) HIV risk stratum	Have access to PEP following nosocomial HIV exposure as part of a package of risk assessment and support.	(90, 80, 70, 50%)
Adolescent girls and young women in high and moderate HIV risk strata	Receive economic empowerment interventions.	20%
Adolescent boys and young men in 15 focus countries	Receive voluntary medical male circumcision.	90%
All adults	Combination HIV prevention among adults	tbd
All young people	Meaningful youth participation	tbd

53. Current situation, challenges and opportunities

- If we do not accelerate prevention efforts for young people, we cannot reach our goal of ending AIDS as a public health threat.
- HIV is heavily affecting adolescent girls and young women, particularly in sub-Saharan Africa, where they account for 1 in 4 new HIV infections. Only 41% of high-incidence locations in the most affected countries are covered by combination prevention programmes for girls and women and only one third of those aged 15–24 years have comprehensive knowledge of HIV, with even lower coverage rates among young key populations. Female-controlled HIV prevention methods are scarce and not prioritized. Young people with disabilities face unique challenges.
- The epidemic is also affecting adolescent boys and young men in sub-Saharan Africa. Those aged 15 years and older are less likely than women to access HIV testing and ART, and less likely to attain viral suppression. Coverage of voluntary medical male circumcision falls short of the target of 25 million circumcisions. COVID-19 lockdowns have led to the widespread suspension of voluntary medical male circumcision services (although many are now restarting).
- While analysis of the HIV epidemic among young people recognizes the risk and vulnerability of young women and girls in generalized epidemic contexts, there is insufficient analysis of the risks faced by young key populations in concentrated epidemic contexts.
- Legal, economic, social and structural factors, especially gender inequalities, stigma and discrimination, increase adolescents' and young people's vulnerability and reduce their ability to access essential HIV services, including intersecting forms of discrimination and barriers for adolescent girls and young people. Young people, and young women in particular, are heavily affected by sexual and gender-based violence. Globally 1 in 5 young people are not in employment, education or training (3 out of 4 young people are women), with those gaps exacerbated by COVID-19 lockdowns.
- Programmatic gaps undermine HIV prevention for young people: condom use among young people has decreased in many countries; access to PrEP among young people remains inadequate; coverage of HIV prevention and treatment among male partners of young women remains low; restrictive policies, lack of reliable data and a failure to consider specific prevention needs of young people in key populations undermine prevention efforts for young people. Meaningful youth engagement and influence in programmatic and policy decisions must be scaled-up.

54. Priority actions to achieve targets and results

- a) Bring to scale youth-centered, youth-friendly, gender-responsive HIV combination prevention and sexual and reproductive health services, applying differentiated

approaches for specific populations and locations. This includes urgently expanding testing, linkage to and retention in ART; integrating HIV prevention, testing and treatment in sexual and reproductive health programming; youth-centred demand generation (including comprehensive sexuality education); condom access; voluntary medical male circumcision; PrEP; expansion of female-controlled prevention options; integration of mental health interventions; and targeted efforts to address the needs of young key populations. Youth-led and peer-based approaches are essential to effectively reach young people.

- b) Increase the enrolment and retention in primary and secondary schools for adolescent girls and provide linkages to combination social protection, "cash plus" interventions, economic empowerment, financial incentives and pathways to employment.
- c) Strengthen provision of good-quality, comprehensive sexuality education in-school, including through support for curriculum review/revision, teacher training, and more inclusive programming for young people living with HIV, adolescent and young members of key populations and young people with disabilities. Expand comprehensive sexuality education programming for out-of-school young people, including targeted programmes for adolescent key populations and young people with disabilities. Expand research and programming on comprehensive sexuality education in digital space (including steps to ensure young people's online safety, privacy and security). Engage parents, communities, indigenous leaders, religious leaders and the private sector to strengthen education and youth-friendly services for young people who are living with HIV. Engage young people who are living with HIV as agents of change for the prevention response.
- d) Address the legal, social and structural drivers of risk and vulnerability among adolescents and young people, including eliminating gender inequality and transforming unequal gender norms. Prevent and protect young people from all forms of sexual and gender-based violence. Urgently remove barriers to adolescents' access and use of services. Ensure adequate investment in social support and social protection systems that are accessible for young people. This will require a systematic approach to community-led outreach and engagement around HIV prevention and associated gender norms, with differentiated communications and entry points for women, men and young people.
- e) Meaningfully engage and empower adolescents and young people (including men and boys, but particularly adolescent girls and young women in all their diversity in settings with high HIV burdens and young key populations) and communities to lead and manage community-led HIV responses, including young people living with HIV as agents of change for the prevention response.
- f) Strengthen data and evidence systems, capturing more granular and real-time data for planning (e.g. population size, location, risk stratification that takes account of intersectional vulnerabilities), robust results and monitoring frameworks. Rapidly enhance country capacity to develop, monitor and analyse HIV-specific indicators across sectors, including reviewing data on young people with intersectional vulnerabilities (e.g. young key populations, adolescents in conflict situations, adolescents with disabilities) and conducting gender analysis.
- g) Explore domestic solutions and partnerships with the private sector to ensure sustainable investment in financing of programmes for adolescents and young people.

RESULT AREA 4: Tailored and scaled HIV combination prevention and related HIV and health services accessible to and utilized by key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people and prisoners)

2025 Targets

Population	Target	Percentage
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Key populations	HIV testing and treatment.	95–95–95
Key populations	Use appropriate, prioritized, person-centred and effective combination prevention options, by 2025.	95%
Key populations	Access linked or integrated person-centered health services (not disease-specific) as defined in detailed integration targets.	90%
Indicative targets disaggregated by populations		
All key populations	Regular contact to health/ community-led services.	90%
All key populations	Condom use (or PrEP or effective ART treatment/viral suppression / U=U).	90%
Sex workers		95%
Sex workers in (very high, high, moderate/low) HIV risk stratum	PrEP targets stratified by risk measures.	(80, 15, 0%)
Gay, bisexual and other men who have sex with men (very high, high, moderate/low) HIV risk stratum	PrEP targets stratified by risk measures.	(50, 15, 0%)
People who inject drugs	PrEP targets stratified by risk measures.	(15, 5, 0%)
Transgender people	PrEP targets stratified by risk measures.	(50, 15, 0%)
Prisoners	PrEP targets stratified by risk measures.	(15, 5, 0%)
All key populations	Sexually transmitted infection services.	80%
All key populations	Harm reduction.	Access as needed
People who inject drugs	Needles and syringes.	95%
Prisoners who inject drugs		95%
People who inject drugs	Opioid substitution therapy.	40%
Prisoners who inject drugs		40%
Integration targets		
Gay, bisexual and other men who have sex with men	Have access to HIV services integrated with (or link to) sexually transmitted infection, mental health and intimate partner violence programmes, sexual and gender-based violence programmes that include PEP, and psychological first aid.	90%
Sex workers	Have access to HIV services integrated with (or link to) sexually transmitted infections, mental health and intimate partner violence programmes, sexual and gender-based violence programmes that include PEP and psychological first aid.	90%

Transgender people	Have access to HIV services integrated with or linked to sexually transmitted infections, mental health, gender-affirming therapy, intimate partner violence and sexual and gender-based violence programmes that include post-exposure prophylaxis (PEP), emergency contraception and psychological first aid.	90%
People who inject drugs	Have access to comprehensive harm reduction services integrating or linked to hepatitis C, HIV and mental health services.	90%
People in prisons and other closed settings	Have access to integrated TB, hepatitis C and HIV services.	90%
People on the move (migrants, refugees, humanitarian settings, etc.)	Have access to integrated TB, hepatitis C and HIV services, in addition to intimate partner violence programmes, sexual and gender-based violence programmes that include PEP, emergency contraception and psychological first aid.	90%

55. Current situation, challenges and opportunities

- Key populations and their sexual partners account for an estimated 62% of new infections among adults globally, an even higher proportion of new infections in most regions outside sub-Saharan Africa:
 - 99% in eastern Europe and central Asia,
 - 97% in the Middle East and North Africa,
 - 96% in western and central Europe and North America,
 - 98% in Asia and the Pacific,
 - 77% in Latin America,
 - 69% in western and central Africa,
 - 60% in the Caribbean,
 - 28% in eastern and southern Africa.
- In 2019, almost one quarter (23%) of new adult HIV infections were among gay men and other men who have sex with men. Approximately 10% of new adult HIV infections worldwide were among people who inject drugs, and 8% of new adult infections were among sex workers of all genders. Transgender women accounted for a small proportion of new HIV infections worldwide, but for a disproportionately large percentage of new infections in Asia and the Pacific (7%), Latin America (6%) and the Caribbean (5%).
- Programmatic and data gaps and weaknesses undermine progress in addressing HIV among key populations. Overall, substantial service gaps persist, indicating major gaps for key populations across the testing and treatment cascade. Less than half of sex workers and only about one third of people who inject drugs and gay men and other men who have sex with men are reached by prevention programmes. Only 1% of people who inject drugs live in countries with adequate harm reduction coverage, with disproportionately low access among women who inject drugs. Availability, accessibility and coverage of HIV services for people in prison remains limited.
- Investments in HIV prevention programming for key populations remain acutely inadequate. Less than 3% of overall global HIV spending and less than 12% of global HIV prevention spending were allocated to targeted key population programmes. In most low- and middle-income countries, there is inadequate domestic investment in these programmes, which tend to depend on external financing.
- Insufficient political commitment has also resulted in chronic under-funding of HIV prevention efforts overall and the slow reduction in new HIV infections. International development assistance for HIV prevention decreased by 44% between 2012 and 2017. Domestic investment in HIV prevention, in particular for key populations, remains

insufficient. While attention to HIV prevention increased in proposals to the Global Fund in the first half of 2020, many countries face competing priorities and stigma and discrimination barriers. Global Fund allocations on their own will not close current coverage gaps in HIV prevention. This suggests that a combination of increased domestic investment, prioritization and efficiency is required.

- Service delivery by nongovernmental partners, including community-led services funded by domestic governments (“social contracting”), has proven to be effective, cost-efficient, and inclusive for key populations in many countries. However, these approaches remain underutilized in many countries and still lack political support and technical expertise.
- Stigma, discrimination and policy barriers decrease key populations’ access to services. Criminalization, harassment and violence, including on the part of police, and multiple levels of stigmatization and discrimination fuel the epidemic and deter many people belonging to key populations from accessing HIV prevention, treatment and care services. Despite global commitments, there is regression in repealing punitive laws affecting key populations. Many key populations from racial or ethnic minorities also face intersectional challenges that increase their vulnerability and reduce their service access.
- Challenges for adolescent and young key populations to access services persist, due to legal and structural barriers, including barriers related to gender and age. They include lack of comprehensive sexuality education and of access to prevention (including HIV and sexually transmitted infection prevention information), testing and treatment services, as well as to age-appropriate counselling, care and support (including psychosocial support).

56. Priority actions to achieve targets and results

- a) Prioritize reaching key populations first in HIV programming efforts, including through major increases in investment for evidence-informed key population programming (including domestic investments); sustainable investments in high-quality, differentiated and community-led services; cultivating key population champion countries to promote good practices and advocate for inclusive key population services; focusing programming on high-burden subnational geographies (including cities); and leveraging local support and partnerships to identify innovative and sustainable multisectoral approaches, including through the use of the “Key Population HIV/STI Implementation Tools” and WHO consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations, to guide and prioritize actions for key populations.
- b) Address structural and human rights barriers through enabling interventions, including: empowering and mobilizing communities by ensuring the meaningful engagement and leadership of key populations in all aspects of the response; strengthening community systems (including for scaled-up key population-led services); and expanding peer-to-peer mechanisms for technical support.
- c) Effectively address violence and other human rights abuses, by protecting and promoting the human rights of key populations, by protecting key populations from gender-based violence and from violence by state actors, and by providing legal assistance, access to justice, social and psychological support and shelters where needed.
- d) Reinforce linkages between key population programmes and social protection that contribute to HIV outcomes, including access and adherence to HIV prevention and treatment.
- e) Urgently reduce legal and policy barriers to the provision of services to key populations (including barriers that specifically affect young key populations) by removing legal hindrances to service access and addressing stigma and discrimination.
- f) Reduce overcrowding in prisons and places of detention, and limit the use of custody sentences to violent crimes.

- g) Ensure that comprehensive packages of HIV prevention services and related health services are available, accessible and affordable for the right population, by using differentiated, integrated, person-centred approaches that address intersectionalities and provide a continuum of care both for individuals who are HIV-negative and individuals who are living with HIV.
- h) Sustain and strengthen condom and lubricant programming for key populations to close gaps in access and consistent use, rapidly scale up availability of PrEP as an additional HIV prevention choice, in particular for populations at highest risk and with high demand for PrEP, and increase key populations' access and retention on HIV treatment and viral suppression (U=U) as an additional HIV prevention option.
- i) Fully implement comprehensive harm reduction and HIV services for people who inject drugs including needle-syringe programmes, opioid substitution therapy and naloxone on a scale that can be easily, voluntarily and confidentially accessed by all people who use drugs, including within prisons and other closed settings.
- j) Expand key population HIV and health services and support by leveraging virtual and other community outreach platforms that ensure safety and anonymity; building institutional capacity of key population-led organizations; expanding peer-led outreach to achieve coverage target; and expanding stigma-free health services.
- k) Ensure valid and robust strategic information for key populations, including by engaging key populations in data generation and utilization; supporting community-led monitoring and reporting; and strengthening data disaggregation and analysis.

RESULT AREA 5: People living with, at risk of, or affected by HIV have access to social protection benefits and support

2025 Targets

Population	Target	Percentage
People living with, at risk of and affected by HIV and AIDS)	Have access to one or more social protection benefits (SDG indicator 1.3.1).	45%

57. Current situation, challenges and opportunities

- Depending on their circumstances, people living with HIV may need socioeconomic support to access and use HIV services, adhere to HIV treatment, and lead healthy lives. Social protection is a human right as well as a necessary requirement for the enjoyment of other rights. Social protection policies and programmes facilitate people's access to social services such as education, health, nutrition, housing and other social services.
- The intersecting inequalities and inequities related to HIV (in combination with poverty, food insecurity, disability, stigma and discrimination, etc.) underscore the need for inclusion of people living with HIV in the social protection programmes. For example, women and girls make up 70% of the workforce in the health and social care sectors and they perform the bulk of unpaid domestic work in the home, child-care and other caring functions. An estimated 86% of indigenous people globally work in the informal economy, where they experience poor working conditions and earn low wages. Migrant workers, representing 4.7% of the global labour pool, mostly work in temporary, informal and unprotected employment, with poor or no social protection coverage.
- People living with HIV, key populations and affected populations are entitled to social protection, which must be included in national legal frameworks. These can include access to universal health services, safety net transfers, inclusion in insurance and pension benefits and other state-facilitated systems that are available to the population. Adolescent girls and young women are at exceptionally high risk of acquiring HIV in

sub-Saharan Africa. They confront a myriad health, economic and social challenges and have urgent need to access social protection.

- Only 29% of the world's population has access to adequate social protection coverage (2 out of 3 children have no social protection coverage, while key populations are recognized as beneficiaries in only 26 countries).
- The top three barriers people living with HIV face in accessing social protection benefits are stigma and discrimination, lack of knowledge about existing programmes, and complicated procedures for accessing existing benefits.
- Pandemics such as COVID-19 highlight the pivotal role of social protection in addressing and mitigating the impact of health crises. Over 200 countries have expanded or started 1400 new social assistance measures in response to the COVID-19 pandemic and national expenditure levels have more than tripled. Many of these benefits help mitigate the impact of HIV and reduce HIV risk. The programmes are dependable and sustainable; and must be embedded in government statutes and systems.

58. Priority actions to achieve targets and results

- a) Strengthen institutions and the technical capacity for HIV social protection by improving the functionality and reliability of government social protection systems. Support the generation of knowledge and evidence to deepen understanding of emerging issues and opportunities in order to influence policymaking and advocacy.
- b) Advance the inclusion of adolescent girls and young women who are at heightened risk or vulnerability to HIV (including those who are pregnant or have recently given birth) to access social protection, and address issues related to unpaid care work in the context of HIV women and young women.
- c) Increase inclusion of key populations and communities' access to social protection and socioeconomic services by removing legal and policy barriers they face when seeking to access social services, particularly for criminalized key populations, by advocating for free health care at the point of use, by addressing other health access barriers, and by providing nationally defined care and support to key populations.
- d) Enhance the livelihoods of people living with, at risk or affected by HIV, by strengthening national capacity to implement and scale-up social protection, such as implementing HIV-focused financial incentives that are linked to clinical outcomes and service access, and by providing economic strengthening programmes and social assistance for eligible people living with, at risk or affected by HIV.
- e) Enhance the inclusion of people with disabilities and indigenous people, and meet their unique needs in social protection, care and support systems
- f) Strengthen civil society and community-led capacity to engage and participate in social protection governance processes.
- g) Generate evidence for policy action by documenting the populations living with or affected by HIV who are systematically excluded from social protection programmes and identifying the barriers they face.
- h) Provide social protection in a sustainable way, using a life-cycle approach: different challenges and shocks throughout life require varied social protection instruments. In addition, solutions need to be sustainable and designed with a long-term approach.

Priority II: Empower community-led responses, eliminate HIV-related stigma and discrimination, protect the health and human rights of people living with and at risk of HIV, promote gender equality and eliminate gender-based violence

59. Getting the HIV response on-track to Ending AIDS by 2030 will require much more effective action to address key social and structural factors that increase HIV vulnerability and diminish people's ability to access and effectively use HIV services. The HIV response must effectively tackle the broad spectrum of complex, often interlinked inequalities and inequities that contribute to HIV transmission and that worsen HIV outcomes.
60. Recognize communities of people who are living with and are most affected by HIV as being central, indispensable actors in efforts to implement sound, people-centred, inclusive and rights-based responses that reduce new infections and deaths and that increase the health and well-being of people living with HIV.
61. Respect, protect and fulfil the human rights of all people, without discrimination. Urgent action is needed to remove human rights barriers including ending punitive laws, policies and practices that undermine sound responses to HIV
62. Achieve concrete, quantifiable progress towards the elimination of stigma and discrimination to improve HIV and broader development outcomes.
63. Foster healthy gender norms and eliminate gender, sexual and intimate-partner violence.

RESULT AREA 6: Community-led responses are fully recognized, empowered, resourced, and integrated for a transformative and sustainable HIV response

64. Commitments from the 2016 Political Declaration

- Ensure that at least 30% of all service delivery is community-led by 2030 through investment in human resources for health as well as in the necessary equipment, tools and medicines, by assuring that such policies are based on a nondiscriminatory approach that respects, promotes and protects human rights, and by building the capacity of civil society organizations to deliver HIV prevention and treatment services; and
- At least 6% of HIV resources are allocated for social-enabling activities, including advocacy, community and political mobilization, community monitoring, public communication, and outreach programmes for rapid HIV tests and diagnosis, as well as for human rights programmes, such as law and policy reform, and stigma and discrimination reduction.

65. Current situation, challenges and opportunities

- Community-led activities are key for HIV responses; for advocating for effective action; ensuring that responses meet communities' needs; planning, designing and deciding programmes; delivering services; and monitoring to ensure accountability. However, engagement of community-led organizations remains inadequate and potential partnerships with governments, such as social contracting, are under-resourced and under-utilized.
- Community-led responses are prevented from reaching their potential due to inadequate levels of support, including insufficient funding for community-led organizations and priorities; lack of recognition and integration of community-generated data in HIV response planning and reporting; limited funding for advocacy due to focus on service delivery; and inadequate data on funding for and coverage of community-led responses.
- Closing of civic space limits opportunities for meaningful engagement and is compounded by tokenistic or inadequate representation and consultation of communities in decision-making spaces and processes. There is uneven access to funding, capacity building and decision-making, especially for adolescent girls and young women, and for young key populations-led organizations.

- Community-identified priorities are not addressed adequately. Continuing legal and policy barriers criminalize communities living with and affected by HIV, which leads to increased stigma, discrimination and violence and creates barriers to access life-saving HIV prevention, testing, treatment and other essential health services. There is inadequate attention to and investment in psychosocial services, especially mental health services.
- Evolving national health and Universal Health Coverage architecture, including efforts to improve inclusive health governance in countries, offers both opportunities and threats to HIV-specific community-led responses.
- COVID-19 has highlighted both the transformative potential and the fragility of community-led services. Community-led responses have pioneered and led many of the innovative approaches that have helped preserve HIV service access during the pandemic. However, COVID-19 and related restrictions have disrupted community-led service delivery and advocacy activities. They have also led to further restrictions on civic space. Lack of planning for HIV-related needs in the context of growing humanitarian crises has had profoundly negative consequences during the pandemic.

66. Priority actions to achieve targets and results

- a) Establish, support and sustain the institutional and technical capacity of global, regional and national networks by and for people living with HIV and all key populations (including those led by women and young people living with HIV) to ensure meaningful representation and engagement in the HIV response.
- b) Support networks of people living with HIV and key populations to have representation in decision-making bodies and to participate in and meaningfully influence the decisions that affect their lives, in line with the principle of the Greater Involvement of People Living with HIV (the GIPA principle).
- c) Establish, support and sustain community-led service delivery for HIV prevention, treatment, care, support and related health concerns, including mental health, by and for people living with and affected by HIV, key populations and other underserved populations at risk of HIV, in order to engage and maintain people in HIV services, including by ensuring that policies and regulatory frameworks enable community-led service delivery and its integration into systems for health.
- d) Support, enable and fully resource community-led advocacy for a sustainable human rights-based HIV response, including for the removal of punitive laws, policies and practices that block the HIV response, actions to reduce HIV-related stigma and eliminate discrimination. Protect, expand and sustain essential civic space for community-led responses.
- e) Support, enable and fully resource community-led monitoring, data collection and research, including research on the factors that affect service access and that advance human rights, and research on good practices in the HIV response for community engagement. Community-generated data must be recognized and integrated into HIV response planning, and it must drive the tailoring of the HIV response to local contexts and the needs of people living with HIV, key populations and affected groups, as well as support advocacy and accountability.
- f) Mobilize robust funding for a sustainable community-led response, including support for community-led engagement, service delivery, monitoring, research, advocacy and organizational capacity, with particular attention to ensuring equitable pay for community-led work.
- g) Support the integration of community-led HIV response into all national HIV responses and systems for health more broadly, and leverage the community knowledge that is gained through the HIV response to support stronger health responses for all.

RESULT AREA 7: People living with HIV, key populations and other people who are at high risk of HIV enjoy their human rights and live with dignity, free of stigma, discrimination, with meaningful access to justice and in enabling legal environments

2025 Targets

Population	Target	Percentage
People living with HIV	Experience stigma and discrimination, by 2025.	<10%
People living with HIV	Report internalized stigma, by 2025.	<10%
People living with HIV	HIV report experienced stigma and discrimination in health-care and community settings, by 2025.	<10%
All key populations	Report experienced stigma and discrimination, by 2025.	<10%
General population	Reports discriminatory attitudes towards people living with HIV, by 2025.	<10%
Health workers	Report negative attitudes towards people living with HIV, by 2025.	<10%
Health workers	Report negative attitudes towards key populations, by 2025.	<10%
Law enforcement officers	Report negative attitudes towards key populations, by 2025.	<10–25 %
Countries	Have punitive legal and policy environments that deny access to services.	<10%
Countries	Criminalize any aspect of sex work, possession of small amounts of drugs, same-sex behaviour and HIV transmission, exposure or non-disclosure, by 2025.	<10%
Countries	Lack mechanisms in place for people living with HIV and key populations to report abuse and discrimination and seek redress, by 2025.	<10%
People living with HIV and key populations	Have access to legal services, by 2025.	90%
People living with HIV who experienced rights abuses	Have sought redress by 2025.	90%
All key populations	Experience physical or sexual violence, by 2025.	<10%
People living with HIV	Experience physical or sexual violence, by 2025.	<10%

67. Current situation, challenges and opportunities

- COVID-19 and other health emergencies have brought to the fore the need to have a human rights-based approach to health services, and it increased recognition of the far-reaching and deep inequalities that exist in societies. This provides an opportunity to advocate more strongly for human rights in health, including in the context of HIV.
- Since HIV was first recognized, HIV has been met with violence, stigma, discrimination and social exclusion, reactions that follow the fault lines of social and economic inequalities, and that are perpetuated by punitive laws and policies which are counterproductive and lack scientific basis. Ending HIV requires progress towards the elimination of the many forms of violence, stigma and discrimination that undermine HIV responses.

- HIV-related stigma and discrimination is driven by fear and misinformation. Knowledge that HIV treatment can lead to viral suppression and that people living with HIV can live long, healthy lives with no chance of passing on the virus to their sexual partners if they are on appropriate treatment has transformed how we understand and approach stigma and discrimination. Community-led campaigns, including U=U, continue to generate evidence for education and stigma reduction.
- Gay men and other men who have sex with men who live in countries that criminalize same-sex relations are 2.2 times more likely to be living with HIV than their counterparts in countries that do have such legal restrictions. The risk of HIV infection is almost five times greater in countries with especially severe criminal penalties.
- Modelling indicates that decriminalization of all aspects of sex work could avert 33–46% of new HIV infections among sex workers and their clients over 10 years. A 2020 study in 10 countries in sub-Saharan Africa linked repressive laws targeting sex work with increased prevalence of HIV infection. For people who inject drugs, a similar study estimated that decriminalization in Mexico, coupled with access to opioid substitution therapy, could prevent 21% of new HIV infections. The findings from those studies suggest that achieving decriminalization in all countries would avert approximately 500 000 new HIV infections among female sex workers, clients, gay men and other men who have sex with men, and people who inject drugs between 2020 and 2030 or about 5% of all HIV infections averted by achieving the 2025 and 2030 targets.
- According to a 2017 systematic review, more than 80% of studies have correlated criminalization of drug use with increased risk of HIV, while a separate analysis found that repressive policing of drug use is associated with HIV infection, needle sharing and avoidance of harm reduction programmes.
- The legal and policy environment continues to reflect and reinforce stigma and discrimination against people living with HIV, key populations and others at risk of HIV (92 countries criminalize HIV exposure, nondisclosure and/or transmission; 32 criminalize or prosecute transgender persons; 69 criminalize same-sex sexual activity; 87% and 83% criminalize or otherwise punish some aspect of sex work and drug use/possession for personal use, respectively). At least 48 countries still retain HIV-related travel restrictions, 47% of countries require parental or guardian consent for HIV testing and 34% require such consent for sexual and reproductive health services for people younger than 18 years. When surveyed, 1 in 3 women living with HIV report having experienced at least 1 form of discrimination related to their sexual and reproductive health in the previous 12 months.
- Many countries have toughened their laws and policing practices towards key populations, and have adopted laws and policies restricting space for civil society, sexual and reproductive health and rights, and gender equality. Between 2012 and 2015, 60 countries passed 120 laws restricting the activities of NGOs. The human rights of people living with HIV, key populations and others at risk of HIV continue to be violated in health-care settings and elsewhere, leading to lower rates of employment, higher rates of violence and diminished access to health services, among other consequences. Violence against women—an acute form of gender-based discrimination and human rights violation—is widespread and affects women’s abilities to prevent HIV and mitigate its impact.
- People living with HIV and key populations confront significant barriers and difficulties in accessing justice and redress when they experience rights violations such as violence and discrimination. In far too many countries, legal literacy remains low and there is a lack of mechanisms and support to facilitate meaningful access to justice.
- HIV-related stigma and discrimination remain common across a variety of settings including health-care, workplace, education, community, justice and humanitarian settings. They are often intersectional in their reach and impact: in 25 of 36 countries with recent data, more than 25% of people aged 15–49 years displayed discriminatory attitudes towards people living with HIV. In addition, people living with HIV, women and

girls and people from key populations and other populations who are at high risk of HIV infection experience significantly higher rates of violence compared to the rest of the population.

68. Priority actions to achieve targets and results

- a) Remove human rights obstacles that hinder access to HIV prevention, testing and treatment, including by eliminating discrimination, and by protecting privacy, confidentiality, informed consent and freedom from mandatory testing or forced/coerced medical treatment.
- b) Urgently scale up investments in human rights programmes, guided by data and evidence, including data collected by communities, and ensure that survivors of HIV-related human rights violations have access to timely support.
- c) Remove punitive and discriminatory laws, policies and practices, and general laws that are used to target key populations, as well as travel restrictions, laws criminalizing HIV non-disclosure, exposure and transmission, and laws that discriminate on the basis of gender.
- d) Reform law enforcement practices regarding key populations, people living with HIV and other groups vulnerable to HIV, to support rather than impede the right to health and the HIV response, including by removing discriminatory, arbitrary or punitive practices and by reforming approaches to imprisonment, including ensure access to health care.
- e) Urgently increase investment in meaningful access to justice for people living with HIV, key populations and others who are at risk of HIV, including through community-led legal and rights knowledge and literacy (including on sexual and reproductive health rights for young people) and through access to legal counsel and redress mechanisms such as national human rights institutions and legal aid networks.
- f) Scale up country actions and accountability to eliminate stigma and discrimination, and develop enabling laws and policies through the Global Partnership for Action to eliminate all forms of HIV-related stigma and discrimination, and ensure that digital health technologies and innovations advance the right to health and access to services without violating or impeding other human rights (e.g. rights to privacy).
- g) Support the rights-based deployment and access to health technologies and innovations, including digital technologies, among people living with HIV, key populations and others at risk of HIV, including the protection of privacy, freedom from violence, stigma and discrimination.
- h) Reform laws and policies to support and enable social contracting, as well as the leadership, meaningful participation and adequate resourcing of civil society and community-led organizations in the HIV response, including for human rights programmes, monitoring and advocacy, and do so without discrimination.

RESULT AREA 8: Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV

2025 Targets

Population	Target	Percentage
Women and girls	Experience physical or sexual violence from an intimate partner, by 2025.	<10%
All key populations	Experience physical or sexual violence, by 2025.	<10%

People living with HIV	Experience physical or sexual violence, by 2025.	<10%
People	Support inequitable gender norms, by 2025.	<10%
	HIV services are gender-responsive, by 2025.	>90%
Women, girls and key populations	Experience gender inequality and violence.	<10%

69. Current situation, challenges and opportunities

- AIDS remains one of the leading causes of death for women aged 15–49 years. It is estimated that about 5500 adolescent girls and young women (15–24 years) acquire HIV every week. HIV heavily affects adolescent girls and young women, particularly in sub-Saharan Africa, where they account for 1 in 4 new HIV infections and only one in three girls have accurate HIV knowledge about prevention methods.
- Gender-based violence continues to be a global pandemic, is a risk factor for HIV and deters women from seeking and accessing HIV services. Women and girls who do not conform to social norms and/or belong to key populations are especially vulnerable to such violence.
- Traditional gender norms and role expectations harm women and girls as well as men and boys, including among key populations. For men and boys, these norms may lead to adoption of behaviours associated with stereotypical perceptions of masculinity (including risky sexual behaviours and poor health-seeking behaviours). Those behaviours put men and boys as well as women and girls at increased risk of HIV infection, and they lead to poorer treatment outcomes and increased AIDS-related deaths among men. Evidence shows that transforming unequal gender norms can increase uptake of HIV services.
- Gender inequality increases the vulnerability of women and girls. In studies from 57 countries, only 55% of married or in-union women (aged 15–49 years) reported making their own decisions about sexual and reproductive health (including decisions on their own health, contraceptive use and whether to have sexual intercourse).
- While access to education is acknowledged as a solid HIV prevention and mitigation strategy, too many girls are not accessing quality secondary education, especially in sub-Saharan Africa.
- Economic inequality and insecurity and the burdens of unpaid care and domestic work heighten women's and girls' vulnerabilities to HIV and contribute to transactional sex among adolescent girls and young women.
- Marginalized women and girls, including indigenous women, women and girls with disabilities, women of racial and ethnic minorities, migrants and women on the move, in humanitarian, refugee, prison and conflict situations or living in rural areas or dense informal urban settlements, continue to face stigma and discrimination and barriers to accessing HIV and other essential services, including TB-related services.
- The risk of cervical cancer is increased in women living with HIV. Globally 5.8% of new cervical cancer cases in 2018 (33 000 new cases) were diagnosed in women living with HIV and 4.9% were attributable to HIV infection (28 000 new cases).
- Gender gaps persist in the HIV response. Availability and use of sex- and age-disaggregated data have improved, but those data do not consistently inform policies, investments and practice. National HIV policies, strategies and monitoring frameworks frequently lack adequate gender analysis. HIV programmes often are not coordinated or integrated with sexual and reproductive health programmes or with programmes to prevent and respond to gender-based violence. Strategies to address unequal gender power dynamics and other structural drivers of HIV are not implemented at sufficient scale to effectively complement biomedical interventions.

- While there is a growing acknowledgement of the importance of meaningful involvement and leadership by networks of women and girls living with or at high risk of HIV in decision-making for the HIV response, stigma and discrimination and barriers remain high, and this engagement remains inconsistent and is neither institutionalized nor funded adequately.

70. Priority actions to achieve targets and results

- a) Implement coordinated, comprehensive, scaled-up actions involving a range of stakeholders and to build synergies with gender equality-related actions across different sectors. Gender equality is everyone's business. Addressing inequalities improves outcomes for people across areas, including in the context of HIV.
- b) Draw on a comprehensive gender analysis and give specific attention to population groups who are most left behind (these may include adolescent girls and young women; women who are pregnant; married adolescents; women among key populations; female partners of key populations; migrants; displaced, refugee women and girls or people in conflict-affected and other humanitarian settings; racial or ethnic minorities, including indigenous women or women of African descent living in non-African countries).
- c) Take urgent action to prevent and respond to gender-based violence in the context of HIV, including integrating referral to gender-based violence prevention and response into HIV services, ensuring that links between HIV and gender-based violence are mainstreamed across the response, and ensuring the availability of post-exposure prophylaxis for survivors of rape.
- d) Address harmful gender norms (such as female genital mutilation, child and forced early marriage, and denial of safe, confidential services for sexual and reproductive health for adolescent girls and young women) and gender inequality, and promote women's rights in the context of HIV, including by linking HIV responses to broader efforts to promote women's economic empowerment, by ensuring access to justice for women living with HIV and for key populations, and by ensuring adequate, accessible gender- and adolescent-responsive complaint and redress mechanisms for rights violations.
- e) Enable adolescent girls and young women to complete their schooling and access quality comprehensive sexuality education and youth-friendly services, and invest in multisectoral approaches that address their multifaceted needs and rights.
- f) Implement large-scale human papillomavirus vaccination and cervical cancer screening particularly for adolescent and women living with HIV and especially in southern Africa and eastern Africa, where a substantial HIV-attributable cervical cancer burden is adding to the existing cervical cancer burden.
- g) Engage men and boys in all their diversity as agents of change for gender equality and for addressing harmful masculinities. Transform gender norms and harmful masculinities, including through community-led mobilization, and engage girls and boys from an early age.
- h) Strengthen the collection of sex- and age-disaggregated data and its use for intersectional analysis and decision-making. Strengthen gender equality expertise in AIDS coordinating bodies and key ministries.
- i) Invest in women/young women-led community-based services and responses and in meaningfully engaging women's and young women's organizations and networks in all aspects of the HIV response. Gender equality expertise in AIDS coordinating bodies and key ministries should be strengthened.
- j) Match external commitments to gender equality with internal investments, policies programming, and accountability mechanisms in our own organizations to uphold gender equality internally at all levels and across all systems and processes in the HIV response so that UNAIDS is a role model of equality, equity and nondiscrimination.

- k) Leverage science and innovation to promote gender equality in the context of HIV, including advocating for and monitoring the inclusion of women and girls in clinical trials, addressing gaps in digital skills of women and girls and rethinking approaches to effectively reach and engage adolescent girls and boys and young people in all their diversity.

Priority III. Strengthen resilient, inclusive and fully-resourced HIV pandemic responses and systems for health to protect against financial, humanitarian and health crises

71. A robust, sustainable response is needed to end AIDS as a public health threat by 2030 and to maintain HIV-related gains beyond 2030. This will require a stronger, more diverse and more reliable financing foundation for the HIV response.
72. The HIV response must protect people living with and affected by HIV from unexpected challenges, such as COVID-19, future pandemics and financial crises.
73. A resilient, sustainable response addresses the needs of people living with or affected by HIV, taking account of the contexts in which people live their lives. This will demand effective action to address the unique needs of people affected by conflict and humanitarian crisis.
74. Health services must be optimally people-centred and strategically integrated, and must recognize and address key comorbidities. TB remains the leading cause of hospitalization and death among people living with HIV. Joint HIV and TB programming remains a priority in countries with the highest burden of TB and HIV coinfection, and further strengthens integration, enhancing access to life-saving interventions, while maximizing efficient use of resources. The next Strategy will continue to promote intensified implementation and uptake of key interventions including systematic TB screening among people living with HIV, TB preventive treatment, HIV testing and timely initiation of ART. It will seek to highlight interdependencies with sexually transmitted infections and viral hepatitis, including through the development of polyvalent or integrated diagnostic platforms for combined diagnosis of HIV and coinfections, such as TB, viral hepatitis, human papillomavirus and syphilis.

RESULT AREA 9: Equitable, people-centred sustainable and context-specific integrated HIV and health services support the achievement of AIDS targets within the strengthened, resilient systems for health

2025 Targets

Population	Target	Percentage
Accessing integrated services		
People living with HIV and individuals at heightened risk of HIV infection	Linked to services for other communicable diseases, noncommunicable diseases, sexual and gender-based violence services, mental health and other services they need for their overall health and well-being.	90%

Adolescent girls, young and adult women, including pregnant and breast-feeding women	Have access to sexual and reproductive health and rights services that integrate HIV prevention, treatment and care services. (These integrated services can include, as appropriate to meet the health needs of local population, human papillomavirus vaccination, cervical cancer and sexually transmitted infection screening and treatment, female genital schistosomiasis, screening and/or treatment, intimate partner violence programmes, sexual and gender-based violence programmes that include post-exposure prophylaxis, emergency contraception and psychological first aid.)	90%
Gay men and other men who have sex with men, and sex workers	Have access to HIV services that are integrated with (or link to), mental health and intimate partner violence programmes, and to sexual and gender-based violence programmes that include post-exposure prophylaxis and psychological first aid.	90%
People living with HIV	On TB preventive treatment.	%?
People living with HIV	Reduction in TB-related deaths	%?
	HIV resources are allocated for social enabling activities, including advocacy, community-led and political mobilization, community monitoring, public communication, and outreach programmes for rapid HIV tests and diagnosis, as well as for human rights programmes such as law and policy reform, and stigma and discrimination reduction.	%?
	People living with HIV report experiences of stigma and discrimination in health-care and community settings by 2025.	<10%
All key populations	Avoidance of health-care services due to stigma and discrimination.	<10%
Commitments		
Commit to build people-centred systems for health by strengthening health and social systems, including for populations that epidemiological evidence shows are at higher risk of infection, and by expanding community-led service delivery to cover at least 30% of all service delivery by 2030 (High-Level Meeting on AIDS, 2016).		
The 2018 Astana Declaration reaffirmed the 1978 Alma-Ata Declaration, noting the critical importance of the involvement of individuals, families, community and civil society in the development and implementation of health-related policies and plans.		
Increase global investment for TB prevention, diagnosis, treatment and care to US\$ 13 billion annually. Increase global investment for TB research and development to US\$ 2 billion annually (High-Level Meeting on TB, 2018).		
Percent of facilities report stockouts of antiretrovirals, test kits and condoms (proposed).		
Number of community health workers trained and deployed to provide HIV and other prevention and care services at primary health care level (proposed).		
All countries have their HIV commodity and treatment supply chains reviewed for readiness for COVID-19 and for potential future pandemic disruptions.		

75. Current situation, challenges and opportunities

- Existing health services often fail to address the HIV-related needs of people who need them most, while dedicated HIV services do not always meet the broader health needs of the most marginalized people.
- Broader health system weaknesses undermine effective HIV service provision and discourage further integration of HIV services into health systems.
- Areas of systemic weaknesses include procurement and supply chain management, a lack of transparency on pricing of health commodities and technologies, over-dependence on imported medicines, fragmented and parallel health information systems, an acute shortage of health-care workers in many settings, and end-users' burden of out-of-pocket spending for health-care services.
- The following areas of focus have been identified to support disease specific programmes to align more efficiently in the context of Universal Health Coverage: improve health system strengthening literacy among disease stakeholders; ensure an improved mix, distribution and capability of human resources for health; invest to improve disease surveillance; collaborate with other areas of health to reduce fragmentation; advocate for sustainable health; and understanding different financing approaches and mixes.
- Community-led services play a key role in HIV service provision, as experiences during the COVID-19 pandemic have underscored. But community-led responses remain under-funded and underutilized, and they are insufficiently integrated into health systems planning and financing. Moreover, the transition from donor-led to domestic financing for HIV programmes in many contexts has shifted the focus to primarily health care and universal health coverage governance models and mechanisms (with a diminished role of community-led service delivery).
- Health system weaknesses are compounded by inadequately addressed social and structural factors, such as stigma, discrimination, gender inequalities, sexual and gender-based violence, poverty, inadequate living conditions and insufficient investments in social protection initiatives.
- Increased reliance on out-of-pocket contributions (direct or indirect) from end-users puts vulnerable communities at higher risk of not being able to access health-care services.

76. Priority actions to achieve targets and results

- a) Ensure appropriate, context-specific and effective integration of people-centred services, continuity of HIV services, including for sexual and reproductive health and for coinfections and comorbidities by:
 - developing and/or adapting harmonized and relevant HIV and non-HIV strategies, policies, guidelines and regulations across health and other sectors; by promoting strong leadership and health governance;
 - documenting, disseminating, developing and/or adapting appropriate and population-specific policy and service delivery integration models;
 - optimizing and integrating key systems (e.g. information, testing, laboratory, care and treatment, human resources);
 - optimizing collaboration between national HIV and TB programmes;
 - harnessing digital and other new health innovations;
 - training, supporting and retaining public and private service providers; and
 - contributing to and informing HIV-sensitive universal health coverage policies and actions that address the needs of HIV, key and vulnerable populations.
- b) Key actions that are needed include targeted approaches which provide integrated services, irrespective of entry point, to meet the diverse needs of people living with HIV and of key and other vulnerable populations:

- scale-up community-led (including key population- and adolescent girls and young women-led) services;
 - adequate, equitable and high-quality integrated services (e.g. for TB, viral hepatitis, sexual and reproductive health, including sexually transmitted infections and cervical cancer, noncommunicable diseases, mental health and HIV); and
 - differentiated health services that are capable of addressing the needs of diverse populations available in all settings.
- c) Improve procurement and supply chain management mechanisms, including through:
- strengthened strategic information to monitor supply continuity and competitive pricing;
 - joint price negotiations and pool procurement platforms for coinfection- and comorbidity-related products;
 - enhanced transparency on pricing and intellectual property landscapes; and
 - the promotion of legal and policy coherence, advocacy, policy guidance, south-south and north-south cooperation and technology transfers for local production, strengthened regulatory and production capacities, increased investments in research and development for new health technologies (e.g. long-acting drugs, vaccines and microbicides for HIV), and increased affordability of HIV-related health technologies through reduction of access barriers.
- d) Ensure access to equitable, dignifying, stigma- and discrimination-free health-care services, including measures to eliminate stigma and discrimination in health-care services; routine review and revision of policies and practices across the health-care sector to promote equitable, people-centred services; regular monitoring of stigma and discrimination indicators in health-care settings (including through community-led monitoring), and integration and preparedness of health-care services in humanitarian and crisis settings.
- e) Undertake multisectoral collaboration to promote and advance the human rights of people vulnerable to HIV (including linking health with social protection programmes for people living with HIV, adolescent girls and young women, and key populations, and supporting and engaging in multisectoral platforms to prevent and eliminate human rights violations and inequities, including gender-based violence).

RESULT AREA 10: Maximize efficiency and sustainable resources for effective and equitable HIV responses to achieve 2025 targets and sustain the gains

77. Targets for resource needs by 2030 will be made available in mid-December 2020.

78. Current situation, challenges and opportunities

- Declines in funding for the HIV response and a changing financial landscape for health and development, including due to the impact of COVID-19, impede progress of the HIV response and achievement of SDG3. In 2016, the General Assembly agreed to a steady expansion of investment in the HIV responses of low- and middle-income countries, increasing to at least US\$ 26 billion by 2020, which was the amount required to reach the targets agreed to in the 2016 Political Declaration on Ending AIDS. An increase in the availability of financial resources for HIV responses between 2016 and 2017 suggested that the world was making good on its commitment. Unfortunately, in 2018, investments in low- and middle-income countries decreased by US\$ 900 million to US\$ 19 billion. Total resources available for the HIV response in 2019 were nearly 30% below the Fast-Track resource mobilization target for 2020.
- The financial sustainability of the HIV response is increasingly intertwined with the broader health integration agenda, including universal health coverage. The financing landscape is changing rapidly due to the impact of COVID-19, other emerging health

and development priorities, changing donor priorities and changes in country-specific macroeconomic conditions.

- Even with accelerated resource mobilization efforts, external donor resources remain essential. Many countries remain heavily dependent on donor assistance, and the increase in domestic expenditure that fueled increases in HIV resources in earlier years has recently levelled off. Domestic resources are key, but domestic resources from governments constitute only about 6% of total HIV resources in low-income countries, 19% in lower-middle-income countries, and 74% in upper-middle-income countries.
- Critical areas of the HIV response remain inadequately funded. HIV prevention, community-led responses, social enablers, human rights interventions and programmes for key populations and adolescent girls and young women are chronically under-resourced. For sustained impact, the HIV response must put equity, rights and the needs of marginalized and key populations and communities at the centre of the financing agenda.
- Under-financing of the HIV response must be viewed within a broader context of under-financing and inefficiencies in health care. Under-investment in health-care and public services has weakened the ability of the HIV response to deal with external shocks and has created new vulnerabilities to shocks such as the COVID-19 pandemic.
- Financing the HIV response must be approached within the broader contexts of financing health and development and must leverage/join partnerships and communities to engage in the macroeconomic agenda and fiscal policy discussions, particularly in the era of COVID-19. New ways to mobilize funds are needed. The HIV response must support close collaboration between health, finance and economic ministries and with international financial institutions to enhance fiscal and budgetary space, including by addressing rising public debt, notably in Africa but also in Latin America and parts of Asia, to ensure there are adequate international and domestic resources available for the HIV response.
- The HIV response has shown how a joint political and social movement which attains universal health coverage for a particular disease can achieve gains in life expectancy, health and economic productivity, and advance progress towards broader health and development goals. There is an opportunity to put HIV back on the financing agenda, including through a strong economic and equity angle to support achievement of Universal Health Coverage and relevant SDG targets.
- Financing for HIV, service integration and Universal Health Coverage provides opportunities for synergies. There is a need to strengthen attention to the financial aspects of approaches to develop a minimum health benefit package, including robust HIV services. COVID-19 also presents an opportunity to make use of the increased focus on Universal Health Coverage implementation and health system strengthening, and to reform the financing agenda for development.

79. Priority actions to achieve targets and results

- a) Increase political leadership and social mobilization for equitable and effective governance, policies and delivery platforms to sustain gains in the HIV response. This includes engaging all relevant stakeholders in the HIV response in the financing dialogue; diversifying donor funding to increase investments necessary to get the HIV response back on-track; advocating for increased domestic investments; and expanding partnerships with other organizations, including multilateral financial institutions, to support investing in the HIV response and Universal Health Coverage.
- b) Strengthen the effectiveness, quality and efficiency of the HIV response through evidence-driven and inclusive national strategies, aligned with country systems, that identify the economic costs of the HIV epidemic and catalyze funding for services needed to accelerate the response and sustain results. Increase the use of cost

analysis for planning, budget development and delivery for financial reporting of resources spent.

- c) Increase domestic revenues towards building resilient financing frameworks and cofinancing of an effective multisectoral HIV response, while maintaining diversified donor funding. This can include adopting supportive fiscal policies; integrating HIV response financing in Universal Health Coverage implementation; implementing sustainability frameworks for the HIV response based on domestic resource cascade analysis and COVID-19 impact on fiscal constraints; catalyzing funding and international partnerships to address gaps in middle-income countries, particularly for key populations.
- d) Increase the scale and predictability of long-term, direct funding for community-led responses and strengthen the capacities of community organizations to access diversified financing models, including public financing. This can be done by funding earmarked activities, developing investment cases to galvanize increased commitment, establishing or strengthening existing public financing frameworks and policies; and supporting advocacy by civil society to increase domestic and international resources for the HIV response.
- e) Leverage technologies and innovations to increase transparency, accountability and efficiency of financing mechanisms; utilize data collection and data systems for decision-making and service delivery with enhanced targeting and granularity; develop partnerships with private sector; and monitor market dynamics of HIV-related products, coinfections and comorbidities, ensuring equitable access to technologies.

RESULT AREA 11: People living with HIV and affected or at risk of HIV who are affected by conflict, natural disasters and other humanitarian crises, including refugees, internally displaced people, returnees and asylum seekers, as well as among vulnerable migrants in other contexts, access the HIV-related services they need to protect their health, rights and well-being

2025 Targets

Population	Target	Percentage
People within humanitarian setting at risk of HIV infection	Use appropriate, prioritized, person-centred and effective combination prevention options (disaggregated by humanitarian populations, by sex and by age).	95%
People within humanitarian settings	Have access to integrated TB, hepatitis C and HIV services, in addition to intimate partner violence programmes, gender-based violence programmes that include PEP, emergency contraception and psychological first aid. These integrated services should be person-centred and tailored to the humanitarian context, the place of settling and the place of origin.	90%
People living with HIV and individuals at heightened risk of HIV infection	Linked to services for other communicable diseases, noncommunicable diseases, sexual and gender-based violence, mental health and other services they need for their overall health and well-being.	90%
People living with HIV and individuals at heightened risk of HIV infection	Have access to sexual and reproductive health and rights services that integrate HIV prevention, treatment and care services. These integrated services can include, as appropriate to meet the health needs of local population, viral hepatitis, cervical cancer and sexually transmitted infection screening and treatment, female	90%

	genital schistosomiasis (<i>S. haematobium</i>) screening and/or treatment, intimate partner violence programmes, sexual and gender-based violence programmes that include PEP, emergency contraception and psychological first aid.	
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80. Current situation, challenges and opportunities

- While the magnitude and frequency of humanitarian emergencies are increasing, including complex crises, food insecurity, climate change events and protracted conflicts that deplete health services, isolate communities and increase vulnerabilities, HIV remains inadequately addressed and integrated in emergency and humanitarian responses, funding proposals and preparedness plans.
- The HIV response at the national level is often not inclusive of health risks and vulnerabilities linked to human mobility, scale of mobility flows, interactions between mobile populations and host communities, and potential occurrence of public health threats, including HIV.
- Minimum HIV services are often not implemented in conflict, natural disasters and other humanitarian crises, especially for internally displaced persons. There is slow progress towards providing comprehensive services, including combination prevention, responses to violence and access to treatment for key populations in humanitarian settings, including male, female and transgender sex workers.
- Globally, the largest treatment gap was found for adolescents affected by humanitarian emergencies (79%) as well as children (65%) and pregnant women (43%). Furthermore, adolescent girls and young women in displaced situations and those on the move often feel excluded and their multiple intersecting needs are not addressed.
- Populations in humanitarian settings are least protected by national social safety nets and therefore most vulnerable to the socioeconomic impact of emergencies, which often leads to an increase in behaviours such as selling sex, children dropping out of school and child labour. More attention is needed to identify people living with HIV and link them with treatment and care. Although nutrition, linkages to food security and self-reliance support greatly promote treatment adherence and well-being for people living with HIV, these issues receive insufficient attention in programming.
- Social exclusion, stigma and discrimination towards people living with HIV, key populations and survivors of sexual and gender-based violence, as well as conflict-related sexual violence, are still prevalent in humanitarian contexts. HIV criminalization laws or travel restrictions may impede access to HIV care and treatment services, as refugees and migrants living with HIV may fear expulsion from the host country or prosecution if they disclose their HIV status.
- Many factors can exacerbate risks of gender-based violence in humanitarian crises. While various gendered vulnerabilities are analysed to ensure care and support for all survivors, special attention should be given to females, due to their documented greater vulnerabilities to gender-based violence, discrimination and lack of safe access to humanitarian assistance.
- Community-led responses in HIV are at fledgling stages in many humanitarian situations. Key populations, including sex workers, often are not included or prominent in the response.

81. Priority actions to achieve targets and results

- a) National humanitarian and emergency responses must not neglect people living with HIV and affected by HIV, including people at high risk of HIV infection. Priority actions must be carried out to ensure that people living with HIV and key and vulnerable populations continue to access essential HIV prevention, testing, treatment, care and other integrated services.

- b) For policies, strategies, plans and major funding proposals: strengthen integration of HIV into national and subnational humanitarian preparedness, contingency and response plans, and build capacity and awareness for addressing HIV through a multicluster approach. Integrate refugees, internally displaced and other conflict-affected populations into HIV policy frameworks, programmes and funding proposals in ways that reflect the diversity of needs, including support and scale-up of community-led responses and mobile health facilities.
- c) Ensure the revision of existing laws and policies that hinder migrant, mobile, refugee and crisis-affected population from accessing essential HIV prevention, care, support and treatment services. Include establishing links and integration with food security, nutrition and social protection programmes.
- d) Gender-based violence and gender equality: align and strengthen actions to prevent and respond to gender-based violence and conflict-related sexual violence in all humanitarian settings involving key players (e.g. uniformed services and ex-combatants). Adopt a holistic and survivor-centred approach to gender-based violence and conflict-related sexual violence involving communities and protection services that are capable of addressing needs of diverse sexual orientations and gender identity expressions.
- e) Stigma, discrimination, and human rights: address laws, policies and practices that prevent migrant, mobile populations, and humanitarian -affected populations from accessing rights-based programmes. Ensure monitoring and investigation of policies and practices, collective advocacy, capacity building, and training are needed to remove discriminatory policies such as mandatory testing and subsequent violations of rights for vulnerable and key populations.
- f) Assessment, surveillance, monitoring, evaluation: ensure granular, targeted, and adapted HIV and related programming in humanitarian settings, based on improved surveillance, localized assessment of risks and vulnerabilities, access to services and outcomes, and strengthened community-based monitoring systems that follow and report on availability and access to HIV and protection services.
- g) Ensure diverse partnerships beyond the Joint Programme – to include all relevant actors in development, humanitarian and peacebuilding and peacekeeping coordination, planning and financing mechanisms - inclusive of community-led organization, as well as peacekeeping missions and pursuance of UN security council resolutions as well as other bodies.
- h) Address the root causes of conflict and insecurity that frequently hampers the implementation of health programming in communities. Peacebuilding efforts, community engagement and gender transformative approaches are essential in reducing levels of violence and improving health outcomes among populations affected by humanitarian crises.

RESULT AREA 12: HIV response is fully prepared and resilient to protect people living with, at risk and affected by HIV from adverse impacts of current and future pandemics and shocks

Commitments

All countries' pandemic preparedness and rapid response plans have HIV-inclusive recovery strategies.

All national HIV strategic plans fully integrate co- and multimorbidities in terms of vulnerability, risk factors, integrated service delivery and social policy.

All countries have common service platforms for pandemic preparedness/International Health Regulations core capacity compliance that includes HIV services and services organizations.

Community-led and civil society organizations are part of country response preparedness teams or task forces.

All countries have a civil society pandemic response capacity building plan in place for their meaningful involvement and participation in the response.

82. Current situation, challenges and opportunities

- COVID-19 has had severe health and social consequences for people living with or at risk of HIV and TB. Approximately 90% of countries reported disruptions in essential health services, affecting frontline health, sexual and reproductive health, treatment of mental health disorders, and HIV services, as well as the supply of essential HIV commodities such as ART, PrEP and condoms.
- While an understanding of interactions between HIV, HIV-related immunodeficiencies and COVID-19 is emerging, there are concerns about the well-being of people living with HIV and key populations, including due to the possibility of severe disruptions to HIV prevention, testing and treatment services and commodity supplies. COVID-19 control measures have had a negative effect on utilization of prevention programmes for some key populations, and the suspension of voluntary medical male circumcision services in high-burden countries has impeded service uptake. Utilization of HIV testing services has sharply declined during the pandemic, reducing the number of people initiated on ART.
- In several countries, people living with HIV report being required to disclose their HIV status when seeking HIV services during lockdowns, especially adolescents, women and transgender people. Increases in violence have been reported among women and people from gender and sexual minorities as a result of stay-at-home orders and physical distancing measures. Attacks on lesbian, gay, bisexual and transgender youth under the guise of public health enforcement measures, and lack of social protection and income security for sex workers, have been documented.
- The COVID-19 pandemic's effects on women and girls have been profound, including increased risks of sexual and gender-based violence, interruption of girls' schooling and increasing the unpaid caregiving burdens on women and girls. COVID-19 control measures have also led to human rights violations against key populations and other marginalized groups. Key populations have been disproportionately affected, experiencing violence, exclusion and arrest under lockdown orders. Sex workers have been excluded from financial support measures in most of these countries, while people engaging in sex work have faced arrest. Transgender people and gay men and other men who have sex with men have been subjected to arrest and harassment, and people who use drugs lack safe options for accessing harm reduction services. Overly broad lockdown restrictions have disproportionately affected women—for example, by making it difficult for women in labour to travel to hospitals.
- COVID-19 has also underscored the critical value of social protection benefits and the transformative impact of HIV investments, including for strengthening systems for health. The pandemic has spurred rapid uptake of key HIV-related innovations, including HIV self-testing, multimonth dispensing of medicines and use of virtual platforms for support, counselling, and information dissemination.

83. Priority actions to achieve targets and results

- a) Include in HIV plans a set of strategies for dealing with emergency planning, utilizing HIV capacity and learning to strengthen pandemic preparedness and rapid response. Capitalize on experiences of the HIV response to promote equitable access to safe, affordable vaccines.
- b) Ensure continuity of HIV services, as well as sexual and reproductive health, and the supply of health products, including protection of the health-care workforce and equitable and fair access to pandemic response tools, including vaccines. Ensure

access to self-care options, including HIV self-testing. Increase the uptake digital technology rapidly to mitigate disruptions to services.

- c) Ensure engagement and participation of all sectors of the community in the development of context-specific public health responses to pandemics. Networks of people living with HIV, key populations and women's groups have three decades of experience implementing stigma reduction programmes in the context of HIV, which countries can draw on to support community-based public health responses to health emergencies and pandemic responses.
- d) Strengthen global surveillance and data intelligence on the market dynamics of HIV-related products to ensure rapid response; perform continuous assessment of HIV products' supply and pricing; apply an evidence-based approach to identify gaps in coverage using disaggregated data to inform differentiated service delivery approaches, linkage to service strategies and geographic prioritization of facility and community-based services; and promote evidence-based advocacy to mitigate risks.
- e) Maintain, sustain and further scale-up innovative or modified HIV interventions and service delivery, including those outside and inside health-care facilities and those that are community-led and have proven to be effective during COVID19 pandemic.

Cross-cutting strategies

84. Leadership and country ownership

- Political will and leadership, including renewed political leadership at all levels, and engagement with new and existing political bodies and forums and movements will be required to translate the 2025 targets into policies, strategies, funding and implementation, and to close the major response gaps that impede progress towards ending AIDS as a public health threat.
- Country ownership and leadership will remain a foundation for responses that leave no-one behind. Transformative whole-of-government and whole-of-society approaches will be required to deliver the full spectrum of the response and to protect all people, everywhere. Country-level governance mechanisms will have to be strengthened to effectively support inclusive strategic partnerships, multisectorality, coordination and collaboration.
- Empowered and enable leadership of communities and the meaningful involvement of people living with HIV in all their diversity, including vulnerable and key populations, will remain a critical pillar of inclusive, equitable, effective, efficient and sustainable HIV responses.

85. Programmatic advocacy and communications

- Bold advocacy and communications will be needed to catalyze action to achieve the 2025 targets—and to refocus the world's attention on the urgent need for action to end AIDS as a public health threat and address the often-sensitive social and structural factors that impede progress towards HIV-related goals and targets.
- Stronger advocacy and communications are needed to accelerate implementation of new HIV policies, research and developments in HIV implementation science (e.g. PrEP, uptake of voluntary medical male circumcision, HIV self-testing, transition to optimized treatment regimes, multimonth dispensing of antiretrovirals, and assisted partner notification).
- Mobilization of key influencers can advance progress on sensitive issues (e.g. punitive laws and decriminalization of HIV transmission and key populations) which remain barriers in many countries. They can also assist in addressing inequalities and inequities that hamper access to and use of HIV services by women, girls and adolescents (by advocating for legal and regulatory changes, especially around age of consent, comprehensive sexuality education, and access to sexual and reproductive health services).

86. Partnerships, multisectorality and collaboration

- Ending AIDS is an immense challenge that will require the active engagement and collaboration of diverse partners at all levels.
- The new Strategy calls for further strengthening of strategic partnerships with global partners (including with the Global Fund, PEPFAR, Unitaid, bilateral donors and private foundations) and between governments and communities. It also calls for full alignment between strategic processes (e.g. between the new global AIDS Strategy and the next Global Fund strategy, which is under development, and the strategies of UNAIDS Cosponsors).
- A multisectoral approach to address HIV is critically important to strengthen collaboration and synergies between HIV-specific and broader health and development initiatives, and to address social and structural factors that increase HIV vulnerability, affect service uptake, and to meet the intersectional needs of people.
- The new Strategy will ensure alignment with and positive contributions to the ongoing discourse in the global health architecture, including through the Global Action Plan for healthy lives and well-being for all.

87. Data, science, research and innovation

- The new Strategy stresses the urgent need to accelerate the development of new and better HIV tools (e.g. long-acting ART, new classes of antiretrovirals, new paediatric regimens and formulations, HIV vaccine and functional cure) and for expedited, scaled-up use of innovations in the hands of programmes, service providers and users of services.
- Innovations in service delivery have had a transformative effect in many settings (e.g. differentiated service delivery, differentiated testing, multimonth dispensing, HIV self-testing), especially during the COVID-19 crisis. The rapid uptake of new HIV policies and innovations will reduce barriers and empower people and communities.
- The new Strategy will accelerate the development and use of biomedical innovations (e.g. dolutegravir, improved paediatric regimens, injectable long-acting antiretrovirals, PrEP, and point-of-care diagnostics) and will promote more rapid progress and continued investment in HIV vaccine and cure development.
- Strengthen the use of cutting-edge technologies such as Artificial Intelligence and data science to help identify, support and make available data on HIV- epidemiological, financial and services.

88. Regionalization

- The new strategic targets are global in nature. This reflects the conviction that suboptimal outcomes cannot be accepted in any location or for any population affected by HIV.
- However, the new Strategy will take account of the substantial variations in outcomes between and within regions.
- For some regions (e.g. eastern and southern Africa, central and western Europe and North America), the current trajectory has to be maintained to end AIDS as a public health threat by 2030.
- In regions where progress lags, tailored catch-up plans will get regional responses on-track to achieve the 2030 target of ending AIDS as a public health threat.

89. Evidence-based focus on context, populations and location

- The new Strategy recognizes that “one size” does not fit all. HIV burdens and key epidemic drivers vary widely within and between countries and regions.

- To accelerate progress towards ending AIDS, the next Strategy must be strategically focus on the geographic settings and populations in greatest need. Programmes must be tailored to the specific needs and circumstances of these settings and populations.
- This will require more effective and timely use of granular strategic information in order to guide resource allocation, devise optimally appropriate service packages, and tailor service delivery approaches and community-led engagement strategies in each setting and for each population.

90. Urban / cities

- Approximately 55% of the world's population currently lives in urban areas. That proportion is expected to increase to 68% by 2050. In most countries, cities account for a large and growing proportion of the national HIV burden; in some countries, a single city can account for up to 30% of the HIV burden.
- Risk and vulnerability to HIV is often higher in urban than rural areas due to a range of factors such as migration, overcrowding, and socioeconomic inequalities.
- While the global HIV response has historically focused on national governments as the key driver of public sector action to address HIV, the new Strategy will also emphasize the need to focus on cities as essential partners and change agents in the HIV response. As centres for economic growth, education, innovation, positive social change and sustainable development, cities are uniquely positioned to address complex multidimensional problems such as HIV through inclusive participation from diverse stakeholders, and to close programmatic gaps.
- The new Strategy will reinforce cities' leading role as we move closer to ending AIDS, by closing programmatic gaps and reaching key targets, and by addressing rights issues, social exclusion, and risks and vulnerabilities, while using the HIV response as a pathfinder to address medical, social, environmental and other challenges.

91. Inequalities lens / prioritization

- Whereas the current UNAIDS Strategy relies primarily on overall targets (e.g. 90–90–90), the new Strategy focuses on achieving results for people within each and every population and subpopulation affected by HIV.
- The intersection between a diversity of inequalities and HIV will be explored, measured and analysed, reflecting specific country contexts and the varied experiences of different population groups. In addition, inequalities interact at different stages of life with diverse social determinants of health such as socioeconomic status, ethnicity or territory, culture, as well as other intermediate factors such as HIV, illness and/or disability. This dynamic relationship must also be accounted for in the new Strategy.
- The targets in the new Strategy will be built on granular data and will require special attention to implementing tailored and targeted programmes for people and communities facing elevated risks, and those who are left behind due to inequalities and inequities.
- Building on the shared UN System Framework for Action on equality, the new Strategy will prioritize actions to address these inequalities and inequities, which are at the root of HIV vulnerability and disparate outcomes: gender; income; geography; key population status; indigenous and migrant populations; and people with disabilities. It will promote coordinated short- and long-term actions which governments, civil society and development partners can take to address inequalities for more resilient, inclusive and sustainable economies and societies, as well as better health outcomes.
- In 2019, UN Member States adopted a high-level Political Declaration on Universal Health Coverage. It will be difficult to fulfil the commitment to end AIDS without achieving Universal Health Coverage; inequalities block the way towards both goals. The new Strategy aims to reinforce the need for Universal Health Coverage, taking a rights-based, life-course and cross-sectoral approach to programming.

Role of the UNAIDS Joint Programme

92. In support of the global AIDS Strategy, the Joint United Nations Programme on HIV/AIDS⁵ will lead, coordinate and support global efforts to end AIDS as a public health threat by 2030, as part of the integrated SDG agenda, with a renewed sense of urgency and focus. UNAIDS will ensure translation of the new Strategy and its commitments and targets into global, regional and country and community responses.
93. UNAIDS has unique experience in leading and supporting multisectoral partnerships and inclusive, people-centred, data-driven and rights-based approaches to HIV. With 25 years of experience in responding to the AIDS pandemic, UNAIDS is also positioned to make significant contributions to pandemic preparedness and rapid recovery, and more broadly to further shape global health, by advancing human rights and social justice, promoting gender equality and addressing the inequalities and inequities that are explicitly addressed in the new Strategy.
94. Uniting the UN system's leadership and action on HIV, UNAIDS' added value and contribution to the new Strategy lies within four broad areas.
95. **(i) Leadership, political commitment and accountability, including mobilization and optimization of sustainable and adequate investments**
- Mobilize and leverage political leadership for translating global commitments and targets of the Strategy into investments and action for inclusive, equitable, sustainable HIV responses as part of the integrated SDG agenda; addressing the barriers; closing major response gaps; and reinforcing accountability for decisions and their implementation.
 - Inspire and support countries in developing and implementing their HIV strategies and plans; facilitate inclusive multisectoral partnerships and use its convening power to support a transformative whole-of-government and whole-of-society response that delivers results for people, leaving no one behind.
 - Foster sustainable financing of and national capacities for the HIV response through domestic investments and resources, external funding including from the Global Fund, PEPFAR, Unitaid, and other bilateral donors and foundations, and innovative approaches, and promote investments in sustainable civil society and community responses.
96. **(ii) Results for people at country level**
- Advocate and support countries in translating the commitments and targets of the Strategy into national commitments and targets of a multisectoral, integrated response; provide technical expertise and normative guidance to enable countries to recognize and address the structural barriers and persisting response gaps; guide and support legal, policy and programmatic action, upholding human rights, advancing gender equality, and eliminating HIV-related stigma and discrimination.
 - Leverage multisectoral partnerships and technical expertise for expanded tailored, inclusive and integrated services overcoming barriers, Advocate and provide technical guidance for better integration of HIV into more resilient, equitable systems for health, with community responses integrated, and Universal Health Coverage, social protection

⁵ The Joint United Nations Programme on HIV/AIDS (UNAIDS) leads and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths and to end the AIDS epidemic as a public health threat as a contribution to achieving the Sustainable Development Goals. A champion and forerunner of United Nations reform, UNAIDS unites the efforts of 11 United Nations Cosponsors—UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank—and the UNAIDS Secretariat. The achievement of sustainable results for people is at the centre of the Joint Programme's operations at all levels.

and overall broader people-centered, right based quality integrated services that meet people's diverse needs and advance overall health and well-being.

- Share, promote and support learning from the HIV response: critical approaches regarding communities, human rights, gender, access to medicines and inclusive partnerships and act as an advanced model for UN reform as the only cosponsored Joint Programme in the UN, by spearheading innovative and effective joint work for HIV and the related SDGs and with close collaboration with countries, civil society and communities.

97. **(iii) Community leadership and the meaningful involvement of people living with and affected by HIV**

- Promote and support meaningful involvement of people living with HIV in all their diversity, including key populations, in all aspects of the HIV response and other areas of health and development architectures, including in relation to pandemic preparedness and rapid recovery responses to COVID-19 and other emerging pandemics.
- Promote and support policies, legal frameworks, inclusive governance/ institutional mechanisms and capacity building to empower community-led responses, and mobilize resources for community partners.

98. **(iv) Evidence / strategic information for effective HIV response**

- Lead the world's most extensive data collection on the HIV response and HIV financing, and publish authoritative and up-to-date strategic analyses to monitor progress and track gaps, including through more systematic community-led monitoring, and to strengthen the relevance of interventions and evidence for informed global, regional, national and local responses.
- Leverage science, technology and innovation and act as a catalyst for effective, inclusive and sustainable programming, including by sharing best practices and experiences among countries and regions

99. The value added, the commitments, and the contribution of UNAIDS to the global AIDS Strategy and its impact on the SDGs will be further detailed and operationalized through a new UNAIDS Unified, Budget, Results and Accountability Framework (UBRAF). The new UBRAF will be aligned with the global Strategy's targets and results, responding to regional specificities in order to address an evolving pandemic and political, social and economic context, including related to the pandemic preparedness and rapid recovery. UNAIDS appreciates the value of and commits to conducting more systematic evaluation activities for continuous knowledge building to more effectively and efficiently support countries in the implementation of this Strategy and ensure impact.

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